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MEDIGAP POLICIES: FILLING GAPS OR EMPTYING POCKETS?

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

WASHINGTON, DC

MARCH 7, 1990

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MEDIGAP POLICIES: FILLING GAPS OR EMPTYING POCKETS?

WEDNESDAY, MARCH 7, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:14 a.m., in room 628, Dirksen Senate Office Building, Hon. David Pryor (chairman of the committee) presiding.

Present: Senators Pryor, Glenn, Burdick, Shelby, Reid, Graham, Kohl, Heinz, Cohen, Pressler, Grassley, Domenici, Simpson, and Warner.

Staff present: Christine Drayton, Chief Clerk; Marcia Lecky, Professional Staff; Bonnie Hogue, Professional Staff; Portia Porter Mittelman, Staff Director; Christopher Jennings, Deputy Staff Director; Jeffrey Lewis, Minority Staff Director; Allison Barnes, Minority Professional Staff; and Dan Tuite, GPO Printer.

OPENING STATEMENT BY SENATOR DAVID PRYOR, CHAIRMAN

The CHAIRMAN. Ladies and gentlemen, the Committee will come to order.

I, first, want to apologize to my colleagues and witnesses. I was asked by Senator Mitchell to open the Senate a moment ago and it threw me about 10 minutes late, so I do apologize.

We will get right down to business. We have a very good hearing, I think, scheduled this morning relative to Medigap insurance policies.

Let me say, on behalf of the members of the Committee, I am very, very pleased to convene this session of the Special Committee on Aging. We are all very deeply concerned on this Committee about the understandable confusion that many older Americans have about their health insurance need, what coverage they have, their vulnerability to high pressure, and sometimes unscrupulous sales practices.

Today we are going to highlight those problems that older Americans have, that they continue to face, and we will focus on ways to address these problems.

During the debate on the Medicare Catastrophic Coverage Act, it became very clear to us that many older Americans and their families were very confused about what coverage they had and what coverage they did not have.

As a result, even in the best of conditions, decisions about private Medigap and long-term care insurance are exceedingly difficult to make. On top of these problems, many serious marketing abuses that we will talk about this morning in the insurance business persist in spite of over a decade of State and Federal regulatory efforts.

Such abuses include agent ignorance, high pressure marketing techniques, agent efforts to sell unnecessary and even fraudulent policies, as well as insurance company practices and policies that deny or restrict coverage that seniors thought they had.

In preparation for the hearing this morning, let me state that the committee uncovered a number of startling abuses within the private insurance market. Some of these are variations of old scams, and others are new forms of flim-flam.

While the culprits of these abuses represent a very small number of the agents now selling policies, they do represent, I think, an unacceptable number.

One of the most pervasive scams is the continued widespread misuse of "cold lead" cards. These cards are mass mailed advertisements used to target potential purchasers of a product. Oftentimes the mailers are slick, misleading come-ons that are used to scare or trick vulnerable consumers into buying something of questionable value that they don't need and cannot afford.

What these advertisements do not say is that if you fill out the cards, send them in, your name is sold to an insurance company. Soon there is a knock on the door. Behind me are two interesting examples.

The first, to my right, is from the so-called "Christian Brotherhood." It offers information about a Medigap plan that is now available to "All Church Members." [1] Many of my constituents might feel more trusting of this insurance firm but they shouldn't be.

Despite its name, this Medigap company is not affiliated with any church, not affiliated with any denomination, and if you had a strong magnifying glass, you might be able to read at the very bottom, a nondenominational disclaimer.

The second is a lead obviously designed to look like an official Government document. That is the second card on my right. It offers free information about Medicare. What it doesn't say is that if you respond, you are practically guaranteeing yourself a visit from an aggressive and possibly deceitful insurance agent.

Another scam is the establishment of phony senior citizens' organizations whose mailing lists are used to target insurance leads.

Behind me is a blown-up example of a "cold lead" from the American Response Marketing.[2] This firm offers information not only about its Medigap policy but also invites its readers to join the American Senior Citizen Association.

Interestingly enough, we have recently discovered that the President of the American Senior Citizen Association and the American Response Marketing firm is the same man.

The resourcefulness of abusive insurance marketers has no bounds. Recently, this committee uncovered a "service" that, at first glance, seemed innocent enough. A hospital was providing billing services to attract Medicare beneficiaries. Such a service is very attractive, maybe needed. It sure sounds good to me.

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[1] See p. 61.

[2] See p. 199.

Unfortunately, unbeknownst to the beneficiaries, it was the insurance agents who were providing the billing service. Allegedly, these agents took advantage of their positions and sold patients additional policies. In return for this "service," the hospital received a percentage of the commission from the policies sold.

We could go on and on and this morning. I will just put the rest of my statement in the record. We think that we have basically outlined the problem.

[The prepared statement of Senator Pryor follows:]

DAVID PRYOR ARKANSAS CHAIRMAN

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WASHINGTON, DC 20510-6400

OPENING STATEMENT

SENATOR DAVID PRYOR

Senate Special Committee on Aging

March 7, 1990

"Medigap Policies: Filling Gaps or Emptying Pockets?"

On behalf of the members of the Aging Committee, I am pleased to convene this hearing to discuss the problems surrounding Medicare supplemental insurance or "Medigap." We are all deeply concerned about the understandable confusion many older persons have about their health insurance needs and coverage, as well as their vulnerability to high pressure, and sometimes unscrupulous, sales practices. Today's hearing will highlight many of the problems older Americans continue to face and will focus on ways to address these problems.

During the debate surrounding the Medicare Catastrophic Coverage Act, it became abundantly clear that many older Americans, and their families, are very confused about what's covered and not covered under Medicare and Medicaid. As a result, even in the best of conditions, decisions about private Medigap and long-term care insurance are exceedingly difficult to make.

On top of these problems, many serious marketing abuses in the insurance business persist in spite of over a decade of State and federal regulatory efforts. Such abuses include: agent ignorance, high pressure marketing techniques, agent efforts to sell unnecessary and even fraudulent policies, as well as insurance company practices and policies that deny or restrict coverage that seniors thought they had.

In preparing for this hearing, the Committee uncovered a number of startling abuses within the private insurance market. Some of these abuses are variations on old scams, and others are new forms of flim-flam. While culprits of these abuses represent a small number of the agents now selling policies, they represent an unacceptable number.

One of the most pervasive scams is the continued widespread misuse of "cold lead" cards. These cards are mass mailed advertisements used to target potential purchasers of a product. Often-times the mailers are slick, misleading come-ons that are used to scare or trick vulnerable consumers into buying something of questionable value that they don't need and can't afford. What these advertisements do not say is that if you fill out the cards and send them in, your name is sold to insurance agents. Behind me are two interesting examples:

- o The first is from the so-called "Christian Brotherhood." It offers information about a Medigap plan that is now available to "All Church Members." Many of my constituents might feel more trusting of this insurance representative, but they shouldn't be. Despite its name, this Medigap Company is not affiliated with any church or denomination. If you had a magnifying glass, you might be able to read its non-denominational disclaimer on the bottom of the mailing.
- o The second is a lead that is obviously designed to look like an official government document. It offers free information about Medicare. What it doesn't say is that if you respond, you are practically guaranteeing yourself a visit from an aggressive and possibly deceitful insurance agent.

Another scam is the establishment of phony senior citizens' organizations whose mailing lists are used to target insurance leads. Behind me is a blown-up example of a "cold lead" from the American Response Marketing. This firm offers information not only about its Medigap policy but also invites its readers to join the well-known American Senior Citizen Association. Interestingly enough, we have recently learned that the President of the American Senior Citizen Association and the American Response Marketing firm is the same man.

The resourcefulness of abusive insurance marketers has no bounds. Recently, the Committee uncovered a "service" that, at first glance, seemed innocent enough. A hospital was providing billing services to attract Medicare beneficiaries. Such a service is very attractive; it sure sounds good to me. Unfortunately, unbeknownst to the beneficiaries, insurance agents were providing the billing services. Allegedly, these agents took advantage of their position and sold patients additional policies. In return for this "service," the hospital received a percentage of the commission from policies sold.

While the tactics used to get in the door are shocking, the sales abuses that occur once the agent is inside someone's home are worse. During preparation for this hearing, the Committee was provided with a very enlightening and frightening insurance agent training manual. Many of the listed tactics direct the agent to intentionally mislead or scare the elderly consumer. Suggested approaches to dealing with potential purchasers include:

- "Hello. My name is ________. I'm with the Survey Division of Standard Life and Accident Insurance Company. We're taking a survey of hospital insurance coverage in this area, and I'd like to ask you a few questions..."
- "Generally, look your prospect in the eye when: you ask a question, such as 'Isn't it possible that you could have an accident in the next six months?'"
- "...(Always ask a customer for the names of their friends, relatives and neighbors. This 'implied endorsement' is powerful selling medicine.); [take advantage of] newspaper accounts of serious local accidents, which can work a considerable influence on prospects dramatizing the value of insurance..."

The manual also provides recommended responses to potential buyer's questions and comments. For example:

- Question: "Is that an application you are filling out?"
  Proposed Response: "No, this is a medical questionnaire. It becomes an application when you write your name here at the bottom."
- Statement: "I have insurance that covers me pretty well."
  Proposed Response: "That's true, you do have a fine program. However, no policy can keep up with the rising medical costs for very long, and that's exactly why my company came out with this policy..."
- Statement: "I have never been sick a day in my life."
  Proposed Response: "I hope you never are! But you know that many people enter the hospital each day. Most of them probably felt just like you. And no matter how healthy we are we're still subject to an unexpected injury, aren't we?"

And finally, of course:

- "The Fear Close": "...Point out what can happen to him and his family financially should he be without his coverage and faced with costly medical bills."

Today we will hear from two women who are among the many who have been taken advantage of by insurance agents and their aggressive and misleading sales pitches. Their stories are ones not easily told, and I commend them for their willingness to testify before the Committee.

To help protect people like today's witnesses from marketing abuses and to provide them with more accurate information, several states have started programs that rely extensively on volunteers, with the support of paid staff, to provide one-on-one counseling to older people. A counseling and assistance program provides the opportunity for a senior to seek objective advice about the adequacy of their current coverage and the gaps that they have. Counseling programs can be an effective remedy to some of these marketing and sales abuses we hear about. They also provide greatly needed consumer education. We have representatives from two of these programs here today, and I look forward to their testimony.

In light of the success that a few states have had with counseling programs, Senator Heinz and more than half of the Aging Committee joined me in introducing S. 2189, the Health Insurance Counseling and Assistance Act of 1990 last week. This legislation will give states the ability to establish programs to provide one-on-one health insurance counseling to older Americans.

Finally, in an attempt to provide much needed information about Medigap and long-term care insurance policies, the Aging Committee is releasing a buyer's guide to health insurance. This publication provides important tips to consider before purchasing insurance policies.

If we are going to be successful in assuring that Medigap policies "fill gaps," and not "empty pockets," we must not only address the rapidly increasing premiums that we've heard so much about, but also the unconscionable marketing and sales abuses that will be documented today. I welcome you all to today's hearing and I look forward to the testimony of our outstanding witnesses.

The **Chairman**. To help people today like the witnesses that we have asked to come—we appreciate their attendance from a long way off—several States have now started programs that rely extensively on volunteers to provide one-on-one counseling to older people.

To build on this success, Senator Heinz, myself, and more than half of this committee have joined me in introducing S. 2189, the Health Insurance Counseling and Assistance Act of 1990. This bill, we think, will give the States that needed ability and power to establish programs to provide one-on-one health insurance counseling to older Americans.

Let me say the Committee on Aging is now in preparation of a buyer's guide to health insurance. We think this is going to be a very good service for the elderly throughout America. It will at least, I hope, send off some warning bells if that agent knocks on their door some afternoon.

Now, I don't know which ones of my colleagues arrived here first?

Senator **Reid**. Mr. Chairman.

The **Chairman**. Senator Reid.

STATEMENT OF SENATOR HARRY REID

Senator **Reid**. I would ask permission of the Chairman, I have to be on the Senate floor at 9:30, to make my statement part of the record. I congratulate you on this hearing.

The **Chairman**. Thank you, Senator Reid. We appreciate your being here. We are sorry we got started a little late.

[The prepared statement of Senator Reid follows:]

Opening Statement

Senator Harry Reid

March 7, 1990

Medigap Hearing

Thank you, Mr. Chairman, for providing the members of this Committee with an opportunity to examine current sales abuses in the Medigap insurance market. I would also like to take this chance to thank the witnesses with us today who are lending their valuable time and testimony.

The Pepper Commission released their recommendations regarding long-term care and the uninsured last friday. In this country we are fortunate to have the vast majority of our senior citizens covered by Medicare. Seniors do not figure prominently in the numbers of the uninsured. This is a blessing. However, long-term care costs are far from a blessing.

Perhaps, with the assistance of the Pepper Commission's report, we will be able to produce a solution to the long-term care crises which will allay some of the fears of catastrophic nursing home bills -- fears which make us all prey to insurance salesmen promising no bills at all.

We have a problem with Medigap insurance now, however. I have hope, but little faith that we will be able to quickly solve this nation's long-term care crises. We must, therefore address the issue of sales abuses now. People are being victimized.

I have heard many of the awful stories of older people entering nursing homes only to find out that the insurance sold to them specifically for nursing home coverage would not pay due to a technicality. Recently I heard a story on NPR which astounded me. An elderly woman purchased an insurance policy and soon thereafter entered a nursing home. Upon entry, her Medigap insurance policy which covered nursing home care was cancelled --- cancelled because she "lied." Apparently, the woman had said her weight was less than it actually was. Astounding. Terrifying.

Our first step is to educate the consumer. Chairman Pryor, has proposed legislation which will make grants to states that establish Medigap insurance counseling programs. I am pleased to be a cosponsor of the Chairman's legislation.

Often people are lead astray by insurance salesmen. A program to provide clear and unbiased information to the consumer may help those lucky enough to be able to afford Medigap insurance purchase the right coverage.

Again, Mr. Chairman, thank you for holding this hearing.

The **Chairman**. Senator Grassley.

Senator **Grassley**. I was the first Republican.

The **Chairman**. Well, we will call on you; we have called on a Democrat, Senator Grassley. We appreciate your attendance.

Senator **Grassley**. Mr. Chairman, I am not one of those that have co-sponsored your bill at this point, but after reading all of your material about it, I do ask that I be added as a co-sponsor to your legislation.

The **Chairman**. Senator Heinz and I will be proud to have you on our legislation. Thank you.

STATEMENT OF SENATOR CHARLES GRASSLEY

Senator **Grassley**. I want to thank you for holding this hearing.

Mr. Chairman, many people, not just Medicare beneficiaries, are in a class that includes just too many people in America not understanding very well what they buy in the way of health insurance.

I understand that Congressman Stark discovered that most of the members of the Pepper Commission—that is a group that we would think of as very knowledgeable people, including the Chairman—did not know what problems their health policies would cover.

The situation faced by Medicare beneficiaries is even more complicated than that faced by younger people who purchase health insurance, first, because the Medicare program is very complicated, as those of us who have worked on Medicare policy over the years surely know.

Second, what Medigap policies cover and do not cover in relationship to Medicare, and which Medigap policies might give the best value for the premiums they charge is not very obvious.

Therefore, there are opportunities for the unscrupulous to take advantage of older people who understand that they need a Medigap policy to help protect them against the risk which Medicare doesn't cover but are uncertain as to what Medigap policies might provide or the best way to do that.

One way, and no doubt there are others to help minimize or eliminate that kind of situation, is to provide good consumer information. As I understand it, several States have established programs that provide reliable information about Medigap policies to Medicare beneficiaries.

I understand also that these programs are very popular with retired people, an indication that older people are hungry for reliable information about such policies. So, Mr. Chairman, I think that this is a very good hearing that you are having and I am interested in listening to all sides of the issue, particularly from those people who have had problems.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator Grassley.

Let me, if I could, call on the Ranking Member, the Vice Chairman, Senator Heinz, and then we will call Senator Shelby.

STATEMENT OF SENATOR JOHN HEINZ

Senator **Heinz**. Mr. Chairman, thank you very much. I apologize for not being here at the outset of the hearing to hear all your statement.

You were kind enough to observe that I am not only a co-sponsor of your legislation, but as you know, on behalf of this committee, I held a hearing in Pennsylvania on this subject earlier this year. I am extremely pleased to be here with you.

I think the witnesses can see we have an unusually good turnout this morning for this subject. This is a subject where our committee, I think, is right on target to explore the maze of misunderstanding, misrepresentation and outright fraud that too often confronts elderly consumers when they are faced with the prospect of purchasing a Medigap policy.

Unfortunately, there are legions of unscrupulous salespeople with their pockets full of scams and shams, and that is not new. Only the names of the victims each year seem to change.

Equally distressing is the fact that 10 years ago with the Baucus Amendment, Congress thought that it had closed the lid and locked the trunk on the Medigap insurance side show but, as we found out and as the Chairman will be documenting, in 1990 one out of every three policies on the market fails to meet the Federal loss ratio target set to assure a fair percentage of premium dollars paid out by our seniors are actually returned to them in benefit payments.

As our witnesses today will tell us, high pressure sales and deceptive advertising are an all too common occurrence. That these problems still persist suggests at least three areas in which our current monitoring system has failed.

First, the States clearly have failed to provide adequate regulation of the Medigap providers. Neither can the industry justifiably claim adequate self-policing. Consider the example, if you will, of the persistent problem of duplicate coverage.

The Health Insurance Association of America states that only 15 percent of policyholders have more than one Medigap policy. Multiple policies almost always mean duplicate rather than additional coverage at additional cost.

I, for one, believe whether it is one out of every six or one out of every hundred elderly who fall victim to duplication, it is one too many.

Mr. Chairman, I would like the rest of my opening remarks to appear in the record in full.

[The prepared statement of Senator Heinz follows:]

Opening Statement of Senator Heinz

Good morning. I am very pleased to be here this morning with Senator Pryor and my colleagues on the Senate Special Committee on Aging, to explore the maze of misunderstanding, misrepresentation and outright fraud which too often confronts elderly consumers when they purchase Medigap insurance.

Unfortunately, the legions of unscrupulous salespeople with their pockets full of scams and shams are not new; only the names of the victims have changed. Equally distressing is the fact that ten years ago--with the Baucus Amendment--Congress thought we had closed down the lid and locked the trunk on the Medigap insurance sideshow. Yet, in 1990, one out of three policies on the market fails to meet the federal loss ratio targets set to assure a fair percentage of premium dollars paid out by our seniors actually are returned in benefits payments. As our witnesses today will tell us, high pressure sales and deceptive advertising are an all too common an occurrance still.

That these problems persist suggests at least three areas in which the monitoring system has failed. First, the states clearly have failed to provide adequate regulation of the Medigap providers. Neither can the industry justifiably claim adequate self-policing. Consider for example the persistent problem of duplicate coverage: The Health Insurance Association of America states that "only" 15 percent of policy holders have more than one Medigap policy! Multiple policies almost always mean duplicative rather than additional coverage at unnecessary cost. And I, for one, believe that whether it is one out of every six or one out of every hundred elderly who fall victim to duplication, it is one too many. The attitude of the HIAA and the fact that we rely on the industry itself--including the National Association of Insurance Commissioners--to determine the right standards for Medigap policies, suggests the federal government is whistling in the dark when we should be suspicious about the dangers of self-regulation.

Certainly, with the repeal of Catastrophic Care benefits, the Federal government has failed to fill the Medigap with expanded Medicare benefits at a cost seniors can afford. On January 8, I chaired a field hearing in Harrisburg, Pennsylvania, to investigate skyrocketing Medigap costs in the wake of Catastrophic repeal. The General Accounting Office testified there that most beneficiaries would have been better off financially if Catastrophic Care had remained in effect.

With the door is closed on Catastrophic Care benefits, the elderly face premiums averaging more than $700 per year, and increases of nearly $12.00 per month in 1990. Though the changes do not seem great to those who are earning today's wages, they have a significant impact on the quality of life for low-income elderly who most need Medigap coverage. For example one elderly woman from rural Pennsylvania testified the to afford her Medigap coverage on her $600 monthly budget she will have to cut items from her grocery list, and drop a newspaper subscription which provides a link to the outside world.

Without benefits to fill the gap or effective policing by industry or government, consumer education becomes the most important weapon for the elimination of fraud and fear in the Medigap market. On February 28, Sen. Pryor and I, with fourteen of our colleagues, introduced the "Health Insurance Counseling and Assistance Act" to provide that education. This legislation would provide funding to the states to establish one-to-one health insurance counseling programs, to help individuals cut through the Medigap maze. It would authorize up to $15 million from the Medicare Trust Fund to fill this critical need for information and advice.

I acknowledge even as I act with my colleagues to create this new program--and I think it is an important and necessary new program--that it will not solve the confusing nature of Medigap benefits. With Medigap reforms, we are making the best of a bad situation, and looking to the future when we can patch up the holes in the Medicare umbrella. Today, I look forward to hearing the recommendations of the witnesses on the ways we can wipe out the abuses and educate the elderly to regulate the Medigap market with their own consumer power.

Senator HEINZ. I just want to observe that with the door closed on catastrophic coverage benefits, the elderly in my State, as we discovered late last year and early this year, are facing Medigap premiums averaging more than $700 a year and increases averaging $12 a month this year.

Though the changes may not seem great to those who are earning today's wages, they have a very significant impact—$12 a month is a lot of money to someone who is on a fixed income. Those kinds of increases have a very real impact on the quality of life for low income elderly who most need that Medigap coverage.

Mr. Chairman, I think this hearing is extremely timely, the subject is extremely important, and I look forward to working with you and the other members of our committee to resolve this issue by, at a minimum, passing the legislation that you have introduced.

The CHAIRMAN. Thank you, Senator Heinz. We appreciate your statement. Senator Shelby.

STATEMENT OF SENATOR RICHARD SHELBY

Senator SHELBY. Thank you, Mr. Chairman.

I, too, want to congratulate you and commend you for holding these hearings. They are very necessary. It has been 10 years now.

I also, Mr. Chairman, want to extend a warm welcome to all of our panelists and am particularly pleased to be receiving testimony today from my constituent, Mr. Ronald Gaiser of Birmingham, AL, and also a native Alabamian, Mr. John Hildreth.

Senior citizens are the most rapidly increasing age group in the United States, as we all know. Almost all of these individuals have Medicare and at least 75 percent of these have supplemental Medigap coverage. Yet the spiraling costs of health care, gaps in Medicare coverage, and the ever-inflating premiums for supplemental insurance coverage have left millions of older Americans with a threat of financial ruin should they experience an extended illness.

The demographic shift in the age distribution of our population has heightened the public's awareness of the importance of the availability and affordability of health insurance, especially among the elderly.

The state of desperation in which many senior citizens find themselves with regard to health care is certainly understandable to all of us. Unfortunately, there are those who have exploited concerns in this area and some of our society's most vulnerable citizens are being taken advantage of by deceptive marketing and sales tactics within the private insurance market.

Senior citizens, as we all know, are bombarded on the threat of doom with offers to purchase Medigap policies that are presented as their only hope from certain destruction. Upon closer examination of many of these policies, we find, as we say in Alabama, all that glitters ain't gold.

Congress acted in 1980 to address abuses in the sale of Medigap policies. That was 10 years ago. However, it would seem that we must take additional steps, Mr. Chairman, to insure the integrity of the Medigap provider industry.

It is my belief, Mr. Chairman, that all of our citizens can benefit from programs set up to offer information and guidance on health insurance issues. Mr. Chairman, I am a co-sponsor of the Health Insurance Counseling and Assistance Act of 1990 introduced by you.

This measure, I believe, is a great stride toward addressing concerns about Medigap insurance. I look forward to hearing some of the testimony here.

The **CHAIRMAN**. Thank you, Senator Shelby. I am going to use the early bird rule here, so I will call on Senator Glenn and then Senator Pressler.

STATEMENT OF SENATOR JOHN GLENN

Senator **GLENN**. Thank you, Mr. Chairman. I would ask that my complete statement be included in the record. I would summarize it as follows.

I want to congratulate you because I think you are doing the Lord's work with this hearing in trying to prevent unscrupulous people from preying on the elderly, from those whose incomes are reduced, from those beyond their normal working years, too often buying without good advice, and from con artists.

I would submit that the Christian Brotherhood appears to be the work of the devil. The fake associations, fake marketing, all have one goal, to bilk the innocent and the vulnerable. It is bad enough when it is perpetrated on those in their normal years but to do this against the elderly, it seems to me, is criminal.

I have been on this committee since 1977, shortly after I first got to the Senate. I participated in hearings along this same line back 11 or 12 years ago. Obviously we did a lousy job or we would have corrected the whole thing then. I hope you can finish it up.

Thank you.

[The prepared statement of Senator Glenn follows:]

Senator
John Glenn

News Release

FOR IMMEDIATE RELEASE
March 7, 1990

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OPENING STATEMENT OF
SENATOR JOHN GLENN
AT A HEARING OF
THE SENATE SPECIAL COMMITTEE ON AGING
MEDIGAP POLICIES: FILLING GAPS OR EMPTYING POCKETS?
WEDNESDAY, MARCH 7, 1990

Mr. Chairman, I commend you for holding today's hearing, Medigap Policies: Filling Gaps or Emptying Pockets? Like you I am very concerned about the ongoing fraud and sales abuses in the Medigap insurance market. The elderly, who are the targets of these insidious practices, are among the most vulnerable in our society. Public confusion about recent changes in Medicare catastrophic care coverage has made the situation even more difficult.

As a member of the Senate Special Committee on Aging since 1977, I have long been aware of problems with Medigap insurance. In the late 1970's I participated in the Aging Committee's hearings, chaired by Senator Chiles, to expose abuses in the Medicare supplement market; and in 1980 Congress passed legislation which set minimum standards for private health insurance policies sold to supplement Medicare. But recent reports have shown that, despite Federal and State efforts to regulate the Medigap insurance market, problems still exist.

While the vast majority of insurance companies and their agents are legitimate and provide an essential service, there are a few rotten apples in the barrel. We continue to hear stories of unscrupulous agents presenting themselves as representatives of the government or church groups. Predatory salesmen pass around the names of elderly people who are easy marks, and attempt to sell them multiple and unnecessary policies using fear tactics to close the deal. And one recent study found that 25 percent of all insurance dollars spent by seniors are for overlapping coverage.

In an effort to alleviate these problems, I am pleased to be an original cosponsor of S. 2189, the "Health Insurance Counseling and Assistance Act of 1990." This legislation, introduced by Senator Pryor, authorizes grants to the States to provide information and counseling to older people concerning adequate and appropriate health insurance coverage. The information provided by today's witnesses will be valuable to all members of Congress in understanding the need for health insurance counseling for our elderly citizens, and I thank all of you who have agreed to testify.

Mr. Chairman, I would also like to commend the Committee on the excellent informational brochure, "A GUIDE TO PURCHASING MEDIGAP AND LONG-TERM INSURANCE," which I understand will be available for distribution to the public in a few weeks This too will be a valuable tool in combating deceptive practices that are being used to sell insurance.

Mr. Chairman, again, I commend you for holding this important hearing, and I thank our witnesses in advance for their testimony.

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The CHAIRMAN. Thank you, Senator Glenn. We very much appreciate you being here this morning.

Senator GLENN. Well, I am a co-sponsor.

The CHAIRMAN. Great. I am trying to get all of us. We are going to get all of you on there before it is over, I hope.

I really hope our committee members can linger just for a moment. We have a very interesting 9-minute film that I think you would really profit by seeing. If you could stay or come back, we would appreciate it.

Senator Pressler. Thank you, Senator Pressler for being here.

STATEMENT OF SENATOR LARRY PRESSLER

Senator PRESSLER. Thank you, Mr. Chairman. Congratulations on holding this hearing. I am going to put my statement in the record because you have promised me a film.

Let me add that I think these Medigap policies are very confusing to our senior citizens. I don't know how they figure out what Medigap insurance is and so forth. I see the ads with Ed McMahon on TV, I get mailings myself as a veteran—maybe they are anticipating I am getting old, I am—preparing different types of insurance. I don't know how our people can possibly figure out what the real story is.

Also, I recently heard from a couple in Woonsocket, SD, who were informed by the Principal Mutual Life Insurance Company that their monthly premium effective January 1, 1990, would be so much, it was increased, and they were told that was because Congress had repealed the catastrophic program.

Then they received another increase and they were told that was based on rising health care costs, and so forth. By the way, the repeal of the catastrophic program by Congress cannot be used as a justification for all the increases. There has been some abuse of that excuse, so to speak.

In my opening statement, I cover these matters. I shall not read it all because I want to see the 9-minute film.

The CHAIRMAN. We will place your full statement in the record, Senator Pressler.

[The prepared statement of Senator Pressler follows:]

U.S. SENATE AGING COMMITTEE
STATEMENT OF SENATOR LARRY PRESSLER
HEARING ON MEDICARE SUPPLEMENTAL HEALTH INSURANCE
MARCH 7, 1990

I commend my colleague and friend, Senator Pryor, for chairing this hearing on consumer fraud and abuse in the marketing of Medicare supplemental health insurance (Medigap). The issue of marketing abuse including, but not limited to, agent ignorance and high pressure selling techniques certainly is a problem that affects older Americans. However, the issue is pervasive and includes all Americans. How many of us, if asked, could describe our health insurance policy? Many of us could relate personal experience of agent ignorance.

An abuse that I consider of equal importance is the manner in which the dramatic increase in supplemental insurance premiums was explained to senior citizens. The insurance industry used the repeal of the catastrophic health program to benefit its own purpose. It lead senior citizens to believe that their premium increases were the fault of Congress.

Insurance companies lay the blame for the premium increase on the 1989 repeal of the Medicare Catastrophic Coverage Act. In fact, long before that repeal occurred, which I opposed, insurance companies were warning senior citizens that their premiums would skyrocket if the catastrophic program were repealed. I cannot believe that elimination of the catastrophic program is the principal reason for increasing insurance premiums. My hope is that this and previous hearing on the subject of supplemental insurance will help consumers under the reason for premium increases.

Certainly the repeal of the catastrophic coverage Act has had an affect on premiums. That reason is only part of the truth. The other reasons need to be disclosed and told to subscribers.

Premium increases are a serious matter for all senior citizens, but especially for those on fixed incomes. Many older Americans simply cannot afford a seven to twenty percent premium increase. America's older citizens received only a 4.7 percent cost-of-living adjustment (COLA) in 1990.

Yet their supplemental insurance premiums have gone up by at least seven percent. How can they afford such an increase as well as the higher cost of food, utilities, housing and other necessities? Many senior citizens on fixed incomes will be forced to dip into their modest savings, if they have any, to pay for these increases in their cost of living.

Recently, I heard from a couple in rural Woonsocket, South Dakota. On December 8, 1989, they were informed by Principal Mutual Life Insurance Company that their monthly premium effective January 1, 1990 would be $142.33. (Their December 1, 1989 payment was $118.61 per month.) The reason for this $23.71 increase was placed on repeal of the catastrophic program. Then on February 19, 1990 they received another letter stating that their premium would increase to $195.37 effective April 1, 1990. This $43.07 per month increase was based on rising health care costs, technological advances, an aging population, more testing to avoid medical malpractice and the continuing battle against new diseases. This couple will experience a total premium increase of $66.79 in four months.

Why two separate premium increases? Certainly the insurance company knew about health care inflation, increased utilization and an aging population long before April 1, 1990. It is extremely difficult for people on fixed incomes to plan for one, let alone two, unannounced premium increases. This is an abuse of the same magnitude as high sale marketing techniques.

This example is but one proof that insurance rates would have gone up even if the catastrophic program had remained intact. Why? Health care costs rose once again in 1989. That seems to be one of the primary culprits for this Medigap rate increase. Insurance policies operate as a form of socialized protection. Subscribers pay premiums to a company which in turn pays their bills. Insurance is like a credit card. Eventually the policyholders must pay the bill.

A negative side of this kind of insurance is that subscribers are sheltered from realizing the full impact of health care costs. One may have a policy that directly pays the hospital or doctor. In this situation, the policyholder may not be fully aware of the effect of rising health care costs.

It is time for insurance companies to provide a detailed explanation to seniors of why their premiums will increase and to have only one rate increase in a year. Companies should be accountable to their policyholders. Laying the blame on repeal of the catastrophic program is an excuse. It is no substitute for an honest explanation for health insurance rate increases.

As a member of the Senate Aging Committee, I add my support to a thorough review of the supplemental health insurance industry. The senior citizens of America are victimized to the extent they are not told the whole story.

Senator Pryor, thank you for this opportunity to speak out on behalf of older Americans. I hope this hearing is the first of several on this important issue.

The CHAIRMAN. We think it will be a very instructive film.

Senator PRESSLER. By the way, be sure I am a co-sponsor.

The CHAIRMAN. You are on our bill.

Senator PRESSLER. I was one of the originals.

The CHAIRMAN. You are one of the originals. Thank you, Senator Pressler, a very fine member of this committee.

Senator Burdick.

STATEMENT OF SENATOR QUENTIN BURDICK

Senator BURDICK. Thank you, Mr. Chairman.

I am pleased to join you as a co-sponsor of the Health Insurance Counseling and Assistance Act. This issue seems to come down to the need for separating fact from fiction. The elderly consumers want to know just the facts of their insurance needs.

Mr. Chairman, your bill would provide for the delivery of solid, objective information on Medigap opportunities. I hope it also returns control back to the consumer.

I am sure you will hear many stories today of how salesmen have succeeded in selling unnecessary coverage and fictitious benefits to elderly consumers. Some of the tactics we will discuss here amount to nothing more or less than stealing from the havenots.

North Dakota's Insurance Commissioner, Earl Pomeroy, has recognized the need for providing simple facts to consumers. His office produces and distributes a simple guide to buying insurance. The one-on-one consultation you propose, Mr. Chairman, would be of tremendous assistance in cutting through sales hype. Our elderly need only a comfortable amount of coverage at a fair price.

This panel also focuses on the need to protect the very limited personal finances of older Americans. I am hopeful that calling attention to the issue of insurance fraud will help older Americans cut their insurance costs.

I want to commend my colleagues on this committee for their work to end Medigap insurance fraud and abusive marketing. I want to thank you, Mr. Chairman, for calling this hearing and thank the witnesses for their time and assistance.

The CHAIRMAN. Senator Burdick, thank you for your statement and your presence today.

Senator Cohen.

STATEMENT OF SENATOR WILLIAM COHEN

Senator COHEN. Mr. Chairman, I, too, have a statement I would like to introduce for the record.

The CHAIRMAN. The full body of the statement will be placed in the record.

[The prepared statement of Senator Cohen follows:]

William S. C

OPENING STATEMENT

SENATOR WILLIAM S. COHEN

MARCH 7, 1990

SPECIAL COMMITTEE ON AGING

HEARING ON MEDIGAP INSURANCE FRAUD

Thank you, Mr. Chairman for holding these hearings on an area of great concern to us all.

The elderly in our society deserve our respect and support, particularly when they face the complexities of health insurance coverage. Unfortunately, there are those unscrupulous people who would take advantage of an unsuspecting senior citizen, pretending to offer advice and sympathy when a quick sale of an expensive policy is the only motive.

Because the elderly are concerned about their financial - as well as physical - health, many are easily persuaded that additional insurance policies will protect them from disaster. But too often, these policies duplicate the policy the purchaser already owns. By changing an insignificant word or two, and by employing high-pressure sales tactics, the insurance agent plays on the prospective buyer's fears. The sale is made and the buyer has thrown money down the drain.

Recently a constituent wrote to me, asking for advice on choosing an insurance policy. Fortunately, the Maine Bureau of Insurance Consumer Division offers Maine citizens this counseling. The Consumer Division will send representative to visit the home to review the individual's current coverage, financial obligations, and insurance needs. I was able to put this man in touch with those who could offer him -- free of charge -- exactly the information he sought.

But I was reminded that not every state offers this service and elderly individuals nationwide need the same kind of advice to avoid spending their limited incomes on policies which offer them no additional protection. In Maine, competent advice is only a phone call away. In other states, the elderly have no place to turn.

These hearings will shed light on this serious problem, highlighting the need to offer insurance counseling to our older citizens.

Senator COHEN. I would like to simply say that after reading all the material that has been put together by the staff, the hottest places in hell must be reserved for those who exploit the fears and prey upon the weaknesses of our most vulnerable citizens.

Some of the companies we looked at have produced manuals that promote techniques ranking among the lowest forms of human behavior—that promote stealing from the blind, from the disabled, from the senile, and from the helpless.

These are stories which are going to shock a lot of people in this country and I think will make even more important and impressive the initiative you have undertaken here today. I want to commend you, Mr. Chairman, and proceed with the hearing.

The CHAIRMAN. Thank you, Senator Cohen. Senator Domenici.

STATEMENT OF SENATOR PETE V. DOMENICI

Senator DOMENICI. Mr. Chairman, I want to join in that chorus. I believe this situation out there in our country is a disaster for senior citizens. I hope this committee can make some sense of it and do something constructive about it.

Obviously the rising health care costs are of concern to everyone and we are not going to stop that here with the approach we are taking, but clearly we would make a giant step in preventing those who desire to take advantage of this situation among our senior citizens.

I would say to the committee in the State of New Mexico, quite by a coincidence with reference to this hearing, Mr. Chairman, we have had for 3 years a pilot program in our State which we funded under the Older Americans Act under the Health Insurance and Benefit Assistance Corporation.

We have a number of offices where volunteers are trained and staff is provided to do counseling. We have one model office in the rural area, the city of Las Cruces, where over 170 volunteers have been trained and given some kind of certification for counseling with reference to insurance.

I am not sure that in light of the new evidence as to how far companies might be going to cheat, I am not sure that all of this counseling understands and can adequately address that kind of issue, but before we are finished, I hope we get some further testimony for the committee on how it was structured and how it is working in the State of New Mexico. It might assist somewhat in the drafting of legislation that you have in mind.

The CHAIRMAN. Thank you very much, Senator Domenici. I believe Senator Warner has joined us. Senator Warner.

STATEMENT OF SENATOR JOHN WARNER

Senator WARNER. Thank you, Mr. Chairman.

I simply want to say that I would like to co-sponsor this legislation. I think it has great potential.

The CHAIRMAN. We would be proud to have you on there.

I commend you, Senator Heinz and other members of the committee that have supported this. I will suggest that I will forego any opening statement and get to the testimony.

[The prepared statements of Senator Warner, Senator Bradley, and Senator Wilson follow:]

John Warner

SENATOR JOHN WARNER
March 7, 1990
SENATE SPECIAL COMMITTEE ON AGING
"Marketing Medigap: Elder Care or Elder Abuse?"

MR. CHAIRMAN, SENATOR HEINZ, YOUR CHOICE OF THIS MORNING'S TOPIC IS TIMELY INDEED. WITH THE HIGHLY PUBLICIZED PASSAGE AND SUBSEQUENT REPEAL OF THE MEDICARE CATASTROPHIC PLAN, IT IS NO WONDER THAT MANY OLDER AMERICANS ARE LOOKING TO CONGRESS WITH A SENSE OF CONFUSION.

IN 1988, MEDICARE BENEFICIARIES WERE INFORMED THAT GREATLY EXPANDED MEDICARE CONVERAGE WAS SIGNED, SEALED, AND ABOUT TO BE DELIVERED. DUPLICATE SUPPLEMENTAL COVERAGE WAS PROHIBITED, AND IT WAS HOPED THAT THE COSTS OF MEDICARE SUPPLEMENTS WOULD ACTUALLY GO DOWN. I DO NOT DOUBT THAT MANY MEDICARE BENEFICIARIES DROPPED THEIR SUPPLEMENTAL HEALTH INSURANCE ALTOGETHER.

A YEAR LATER, IN RESPONSE TO AN OVERWHELMING PUBLIC OUTCRY, WE THEN TURNED AROUND AND REPEALED THE CATASTROPHIC PLAN. THIS ACTION CAN ONLY HAVE BEEN RECEIVED IN CERTAIN INSURANCE CIRCLES WITH A SENSE OF GLEE, PROVIDING THE PERFECT EXCUSE TO IMPOSE VASTLY INCREASED PREMIUMS ON UNSUSPECTING MEDICARE BENEFICIARIES.

IT IS MY UNDERSTANDING THAT THOSE OF OUR MEMBERS ALSO SERVING ON THE FINANCE COMMITTEE HAVE BEEN USING THAT FORUM TO FOCUS ON MEDICARE SUPPLEMENT COST INCREASES. IT IS OUR JOB HERE TODAY TO FOCUS PUBLIC ATTENTION ON THE ~~MARKETING~~ ANGLE, THAT IS, TO EXPOSE THE TACTICS OF CONFUSION AND INTIMIDATION WHICH ARE PERSUADING OUR MOST VULNERABLE OLDER AMERICANS TO PURCHASE EXPENSIVE AND UNNECESSARY MEDICARE SUPPLEMENTAL HEALTH INSURANCE, BETTER KNOWN AS MEDIGAP.

WE ARE GOING TO HEAR FROM A NUMBER OF CONCERNED GROUPS INCLUDING ACTUAL VICTIMS OF FRAUDULENT MEDIGAP MARKETING PRACTICES, PRESENT AND FORMER MEMBERS OF THE INSURANCE INDUSTRY, INSURANCE REGULATORS, AND AN IMPORTANT AND INNOVATIVE SOURCE OF SUPPORT FOR OLDER AMERICANS - - ADVOCATES FOR MEDICARE BENEFICIARIES WHO ARE SERVING AS HEALTH INSURANCE COUNSELORS.

WHILE WE HAVE BEEN TOLD THAT MEDIGAP FRAUD IS NOT A WIDE OCCURRENCE, I AM SURE MY COLLEAGUES WILL AGREE THAT EVEN ONE CASE IS CLEARLY UNACCEPTABLE. MEDICARE BENEFICIARIES DESERVE NOT ONLY THEIR EARNED BENEFITS, BUT ALSO THE PEACE-OF-MIND THAT THEY ARE NOT GOING TO BE SUBJECTED TO SOME MEDIGAP SCAM.

MR. CHAIRMAN, WOULD YOU BE KIND ENOUGH TO ADD MY NAME TO THE GROWING LIST OF OUR COLLEAGUES SERVING AS COSPONSORS OF YOUR NEW BILL, S.2189, THE HEALTH INSURANCE COUNSELING AND ASSISTANCE ACT.

I UNDERSTAND THAT OVER A FIVE YEAR PERIOD, YOU WOULD AUTHORIZE THE EXPENDITURE OF $15 MILLION PER YEAR FOR THE ESTABLISHMENT OF STATE MEDICARE AND MEDIGAP COUNSELING SERVICES FOR BENEFICIARIES AND THEIR FAMILIES. IF, THROUGH THIS INITIATIVE, WE CAN HELP MEDICARE RECIPIENTS TO SIMPLY HELP THEMSELVES, WE WILL HAVE MADE A SOUND INVESTMENT.

THANK YOU, MR. CHAIRMAN, FOR YOUR CONTINUING LEADERSHIP ON BEHALF OF OLDER AMERICANS.

Aging Committee Medigap Policy Hearing

Statement

Bill Bradley

Bill Bradley

Mr. Chairman, with the repeal of the Catastrophic Coverage Act and the loss of the benefits that were provided in the bill, we have seen the rise of a great deal of confusion over medigap policies on the part of the elderly. As the Medicare beneficiary and insurers scramble to understand what was lost and what would have to be purchased in order to provide adequate health protection, there are those dishonest and immoral elements in our society that would step into the confusion to prey on the elderly. Too frequently, the elderly are easy prey. They are vulnerable and frightened about dependency and loss of independence. I applaud you, Mr. Chairman, for helping to bring this problem to light. I also applaud you for initiating legislation that I have cosponsored to provide money to states to develop counseling programs for senior citizens.

One of the true roles of government is to provide a measure of protection to those who may fall prey to greed and dishonesty. We must help give the elderly information to make wise decisions about their health care coverage. We must also serve notice to those who will exploit the elderly that plundering of confused older Americans will not be tolerated. I heartily support increased efforts to provide education and counseling for the elderly as well as tough enforcement of laws that protect them from the barracudas of the industry.

STATEMENT OF THE HONORABLE PETE WILSON
SENATE COMMITTEE ON AGING
HEARING ON CONSUMER FRAUD AND ABUSE IN THE MEDIGAP MARKET
March 7, 1990

MR. CHAIRMAN, I AM PLEASED THAT THE AGING COMMITTEE THIS MORNING HAS THE OPPORTUNITY TO EXAMINE A SERIOUS PROBLEM IN THE MEDIGAP INSURANCE MARKET -- CONSUMER FRAUD AND ABUSE.

IT IS OFTEN ASSUMED THAT THE ELDERLY HAVE UNLIMITED ACCESS TO MEDICAL SERVICES THROUGH THE MEDICARE. IN REALITY, SIGNIFICANT GAPS IN COVERAGE EXIST FOR THE 33 MILLION AMERICANS WHO DEPEND ON MEDICARE TO MEET THEIR HEALTH CARE NEEDS.

THESE GAPS HAVE GIVEN RISE TO A MULTI-BILLION DOLLAR PER YEAR BRANCH OF THE PRIVATE HEALTH INDUSTRY. I REFER TO WHAT IS COMMONLY KNOWN AS MEDIGAP INSURANCE. CONCERNED ABOUT ESCALATING HEALTH CARE COSTS AND FEARFUL OF RUINOUS EXPENSES, FOUR OF FIVE SENIORS NOW BUY MEDIGAP TO SUPPLEMENT THEIR MEDICARE COVERAGE -- A $10 BILLION TO $15 BILLION INVESTMENT.

YET MUCH OF THAT SUBSTANTIAL INVESTMENT -- AS MUCH AS $3 BILLION BY SOME ESTIMATES -- WILL NOT IN FACT GIVE THE PROTECTION THAT IS SOUGHT. THE VICTIMS OF TRICKERY, DECEPTION, AND OTHER ABUSIVE PRACTICES BY INSURANCE COMPANIES, FAR TOO MANY MEDICARE BENEFICIARIES EACH YEAR ARE DECEIVED AND MISLED TO PURCHASE POLICIES THAT ARE NOT WORTH THE PAPER ON WHICH THEY ARE PRINTED.

CURRENTLY, MOST OF THE INFORMATION SENIOR CITIZENS RECEIVE ABOUT MEDIGAP POLICIES IS THROUGH DIRECT MAIL SOLICITATIONS, TELEVISION, AND PRINT MEDIA ADVERTISING. MUCH OF THIS MARKETING IS DECEPTIVE, PLAYING ON A SENIOR CITIZEN'S FEAR OF HOSPITALS, NURSING HOMES, AND LARGE MEDICAL BILLS. MANY ADS MINIMIZE THEIR EXCLUSIONS AND LIMITATIONS BY EITHER FAILING TO MENTION THEM OR CONCEALING THEM IN FINE PRINT OR OBSCURE LANGUAGE.

MR. CHAIRMAN, THE PURCHASE OF INSURANCE POLICIES OUGHT TO BE BASED ON FACT -- NOT ON FEAR, FANTASY, OR BLIND TRUST IN A WELL-PAID CELEBRITY SALESPERSON. WE CANNOT ALLOW OUR NATION'S SENIORS, AS A RESULT OF DECEPTIVE MARKETING PRICES, TO BE LULLED INTO PAYING FOR INSURANCE POLICIES THAT HIDE THEIR

LIMITATIONS AND MINIMIZE THEIR EXCLUSIONS IN FINE PRINT OR OBSCURE, LEGALISTIC LANGUAGE.

TO HELP REMEDY THE MEDIGAP ABUSES ABOUT WHICH WE WILL LEARN MORE THIS MORNING, COUNSELING PROGRAMS TO EDUCATE MEDICARE BENEFICIARIES ABOUT THEIR HEALTH COVERAGE NEEDS ARE ESSENTIAL. I THEREFORE AM PLEASED TO JOIN YOU AND OTHER MEMBERS OF THE COMMITTEE IN COSPONSORING THE "HEALTH INSURANCE COUNSELING AND ASSISTANT ACT OF 1990", LEGISLATION THAT WILL ENCOURAGE STATES TO ESTABLISH OR BUILD UPON PROGRAMS TO DELIVER NEEDED INFORMATION, COUNSELING AND ASSISTANCE TO SENIORS REGARDING THEIR HEALTH INSURANCE NEEDS.

TO FURTHER COMBAT THIS PROBLEM, MR. CHAIRMAN, I INTEND TO INTRODUCE LEGISLATION TODAY TO REQUIRE A WARNING LABEL TO BE DISPLAYED ON ALL POLICIES, DIRECT MAIL SOLICITATIONS, ELECTRONIC AND PRINT MEDIA ADVERTISEMENTS INVOLVING THE SALE OF ANY TYPE OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE. SUCH A LABEL WOULD INFORM CONSUMERS THAT ALL HEALTH INSURANCE POLICIES CONTAIN GAPS IN COVERAGE AND ALERT THEM TO THE NEED TO SEEK ADDITIONAL INFORMATION PRIOR TO PURCHASING SUPPLEMENTAL INSURANCE COVERAGE.

I BELIEVE MY LEGISLATION COMPLEMENTS PENDING MEDIGAP REFORM BILLS, SUCH AS LEGISLATION OFFERED BY THE CHAIRMAN AND THE SENATOR FROM WISCONSIN, TO PROMOTE COUNSELING AND ASSISTANCE SERVICES TO MEDICARE BENEFICIARIES.

FURTHER, THE WARNING LABEL PROPOSAL STRENGTHENS CONSUMER COUNSELING PROGRAMS INITIATED IN A NUMBER OF STATES -- INCLUDING MY HOME STATE OF CALIFORNIA -- TO EDUCATE MEDICARE BENEFICIARIES ABOUT THEIR HEALTH COVERAGE NEEDS.

AS A CARING SOCIETY, ONE THAT VENERATES RATHER THAN VICTIMIZES OUR ELDERLY, WE MUST DO MORE TO PROTECT SENIORS FROM INSURANCE RIPOFFS.

I LOOK FORWARD TO HEARING THE TESTIMONY OF OUR WITNESSES WHO, I BELIEVE, WILL GIVE THE COMMITTEE INSIGHT TO THE EXTENT OF THE PROBLEM OF MEDIGAP MARKETING ABUSE.

The **Chairman**. Fine. Thank you, Senator Warner.

I thank all of our colleagues. It looks like we have had a huge majority of our membership here today which indicates the interest out there in this subject.

We are going to hear our first witness. Our first witness is not with us this morning, but we filmed him last night in Clearwater, FL, in the prison.

He is a former Medigap insurance policy salesman. He has had his license revoked. He is—or was—a super salesman. He was coming, we hoped, to actually be here with us this morning at this hearing.

However, the correctional authorities said that he is such a good salesman that the fear was that he would talk us into releasing him and let him go free. Therefore, get ready to meet Mr. Ed Kodish, a convicted felon, former Medigap insurance agent.

If you would dim the lights, this is an 8 minute summary of a 30-minute tape. Let us all meet Mr. Ed Kodish and imagine him knocking at your door some day and trying to sell you an insurance policy.

STATEMENT OF ED KODISH, INCARCERATED FORMER INSURANCE AGENT, ST. PETERSBURG, FL (BY VIDEOTAPE); ACCOMPANIED BY MR. ARNOLD LEVINE, ATTORNEY (INTERVIEWER)

Mr. **Levine**. It is 7 o'clock. We are in the Pinellas County Jail. It is March 6th, and my name is Arnold Levine. I am a local attorney. We have Ed Kodish here. The jail has been kind enough to make their facilities available for the taping of this question and answer session for the benefit of the U.S. Senate Special Committee on Aging.

At this point in time, how many criminal offenses involving taking advantage of the aged did you plead guilty to?

Mr. **Kodish**. I believe it was 19.

Mr. **Levine**. In addition to that, you have some pending charges in Pensacola, FL and Fort Myers, FL for substantially the same thing, right?

Mr. **Kodish**. That's correct.

Mr. **Levine**. Is it your view that some of the fraud on the elderly here in Florida and elsewhere could be stopped?

Mr. **Kodish**. Absolutely. I believe if they would have scrutinized my application, I believe I would have been more careful in what I was doing because I knew somebody was watching me.

Mr. **Levine**. Do you have something more to say?

Mr. **Kodish**. I was not alone in fraudulently receiving an insurance license. There were many other convicted felons, convicted drug dealers, nonresidents of Florida, people with phony Social Security numbers, as well as people using aliases. My application was approved by the State of Florida without any investigation. I then went to work for and participated with a company that did approximately $25 million yearly in premiums, 95 percent to people on Medicare or Medicare disability. With the training I received from three of the four managers at [deleted], I learned how to "cleansheet," which is lying on the person's application on their health history, how to intimidate, forge, manipulate, frighten, and lie to the people who we were told to call on. What we represented, what their policies paid, what the waiting periods were, we were even given cards saying that we were either with Medicare or the Florida Department of Insurance, or even business cards saying that we were representatives of AARP. We were taught when making appointments never to say we were insurance agents, either to say we were routemen from Medicare that were going to be in their area and wanted to drop off their Medicare packets that they requested, or to tell them we were from either the Florida Department of Insurance or Medicare, investigating the agent that sell [sic] them the policy that they now have in effect.

Mr. **Levine**. Did you use these tactics?

Mr. **Kodish**. Yes.

Mr. **Levine**. And did others here in the State use these tactics, to your personal knowledge?

Mr. **Kodish**. Yes, I personally know that.

Mr. **Levine**. Were you able to succeed in gaining entry into the homes of these elderly people?

Mr. **Kodish**. More times than not, I got into the house.

Mr. **Levine**. Were you generally able to and were you successful in connection with the sale of Medicare or long-term insurance to these people?

Mr. **Kodish**. Very successful. We were trained to tell the people only what they want to hear. We were trained to get into the door in any way possible and we were trained, no matter what it takes, to get the check.

Mr. **Levine**. What was the age group of these people? What age range were they generally, who you were dealing with?

Mr. **Kodish**. None under 65, but we primarily went even for the older group, over 75, because they felt—the agency felt that the older they get, the more senile they would be, or more likely they would have the beginning of an Alzheimer's or Parkinson's problem. We were taught never to say we were insurance agents when making these appointments. We were told to say that we were either with Medicare or some investigatory agency from the State, the police, or the Government.

Mr. **Levine**. Would you give us an understanding of how much money you earned?

Mr. **Kodish**. Okay. We were rewarded very handsomely. In the first year at [deleted], I made more money than the President of the United States of America. Besides thousands of dollars in jewelry, trips, clothes, and gifts for my wife—and I was not even in the top 20 in commissions. The commission structure was based on a minimum of 40 percent on some policies, and up to as high as 60 percent on some.

Mr. **Levine**. Now, are you talking about 40 percent and 60 percent—are you talking about that sum going to the salesperson, or are you talking about that sum going to the agency, or what?

Mr. **Kodish**. That 40 to 60 percent came right to the agent. Every agency has a contract with an insurance company that would pay them, of course, above the 40 or 60 percent, but an agent's commission structure started at 40 and went up as high as 60 percent. Renewals only paid 7 percent, so thus it didn't pay for us to tell people to renew. It was more profitable for us to just change their policies to another company.

Mr. **Levine**. Was it the practice, then, to get the elderly to cancel their existing insurance so that a new policy could be written with a different company, a company different from that which they had in order for the agent to receive a substantial percentage of the first year's commission?

Mr. **Kodish**. It was called "rolling." Before the person's insurance lapsed out, we were given [sic] notice which people's policies were coming due.

Mr. **Levine**. Coming due for——

Mr. **Kodish**. For renewal. So that gave us ample time to get out to see them to change them over. We didn't care about it if they had a new waiting period. It didn't bother us. None of us, including me, did have any feelings that they might be, for a period of 60 to 180 days, without coverage because they have to meet a new preexisting waiting period. It didn't bother the agency or the agency's management, either. They didn't care.

Mr. **Levine**. And the President of the United States, in 1 year—how much money did you make?

Mr. **Kodish**. I believe my 1099 Form was $239,000.

Mr. **Levine**. And you say that you were not within the top 20?

Mr. **Kodish**. I don't believe I was. We were taught hardsell, one-stop close training methods and techniques in formal classroom settings. These sessions were described as the "ding-dong school of the seas." Again, we were taught every possible lie to gain entry and every possible lie to write the policy. We were taught to avoid the truth, mislead, omit, lie, pressure, frighten, deceive the senior citizen.

Mr. **Levine**. Mr. Kodish, the insurance industry often claims that agents' unscrupulous practices do not reflect the practices of the agencies and the companies themselves, that these are rogue agents or unusual events. Do you think that is a fair statement?

Mr. **Kodish**. That is not a fair statement because every piece of business we wrote had to be monitored by the agency itself. It had to be approved and verified by the agency itself, so we are not independent in the sense that we send it directly to the company. The insurance carrier itself must go through the agency and they keep files and records of the duplication and triplication. What went on there was a disgrace and criminal. I believe there was tax fraud, mail fraud, insurance fraud, Medicare fraud, grand theft, abuse of the elderly, deceptive business practices, larceny, and bribery and extortion.

Mr. **Levine**. You are talking about your particular experience with an agency, whether or not the fact bears that out. Time itself will tell. I guess the question that the committee would be interested in is broader than that.

Do you have any knowledge or information—and if not, do you have any feeling—as to how widespread the kinds of things you have just described are as it relates to Medicare, Medigap insurance?

Mr. **Kodish**. The only agency I personally know in the State of Florida did $25 million a year. In my opinion, talking to the other agents and being one of their top agents, I believe 60 to 80 percent of it was useless and needless insurance. This is a market that tempts abuse. Its clients are afraid of ill health, ending up on the street because of the cost of nursing homes, or of devastating medical bills that Medicare doesn't cover. The sellers, like me, are trained to prey on these victims.

Mr. **Levine**. Would you be available in the event that some member or some investigator in behalf of the committee would like to go into some more specifics and some greater detail at another time?

Mr. **Kodish**. At their convenience.

Mr. **Levine**. Okay, thank you.

It is now about 7:20 in the evening at the beautiful Clearwater Jail.

[End of videotape presentation.]

The **Chairman**. We have met a Medigap insurance salesman who used to sell—I hope he doesn't get a chance to in the future—Medigap insurance policies. Now we are getting ready to meet two individuals who have purchased these policies.

If we could bring Ms. Charlene Blackburn and Ms. Lois Hibbard to our witness table at this time, we would be happy to receive your testimony.

Let me, if I could, tell our colleagues, Ms. Blackburn and Ms. Hibbard, just a paragraph or two about each of you. We appreciate so much your coming.

Your native State is Kansas and I understand that you now live in the State of California. Ms. Blackburn is going to state that in a period of 4 years, she was sold 13 different insurance policies.

We congratulate you, we understand next month you will be celebrating your 80th birthday.

Your colleague to your left is Ms. Lois Hibbard of Riverside, CA. Ms. Hibbard, I may be wrong, I understand this may be her first trip to Washington, I am not sure, but you are 92 years of age, so we congratulate you on that.

We are looking forward to both of you just telling this committee what has happened in your own situation. Feel free, if you would, to pull the microphone a little closer to you or we will get one of the staff to assist if it doesn't come through clearly enough.

STATEMENT OF CHARLENE BLACKBURN, SANTA CRUZ, CA

Ms. **Blackburn**. As Senator Pryor told you, I am Charlene Blackburn. I am living in California at the present time by way of Oregon. I am a native Kansan.

I want to first thank you for inviting me to Washington to appear before your committee.

The **Chairman**. We thank you for coming.

Ms. **Blackburn**. I'm not a public speaker and Ms. Hibbard tells me she is not either, so you are at our mercy.

The **Chairman**. You are always the best witnesses.

Ms. **Blackburn**. Thank you.

My husband had been ill for about 3 years, seriously ill, and finally passed away. During his illness, he was in the hospital several times and it caused a lot of expense so after his passing way, I decided that I needed some supplementary insurance.

At that time, I received one of the cards you talked about in the mail saying that—giving me the impression that it was a local volunteer representing seniors and all I needed to do was put a little check mark in for further information.

That I did and as a result of that, I received a phone call from an elderly gentleman. He came to call and I was glad to have someone of my peer group talk over these things with me. He was a very nice looking, gray-haired gentleman, a senior I am sure himself.

He explained a lot of things to me. There was no mention of any insurance company that he represented. I got the impression that he was just a volunteer willing to help other seniors. That is how I bought my first policy, from this elderly gentleman.

The next time when he came to the house to deliver the policy, he had with him a young man who was, I would say—he told me later he was about 31 years old, very handsome, very personable and of course I'm here to say he was really a high-powered salesman.

The CHAIRMAN. They had come to your home, is this correct?

Ms. BLACKBURN. This is correct, but it was at my suggestion through the card and all this, and he was delivering the policy. Everything was on the up and up as far as I knew.

I should insert here that, as some of you may know, my generation grew up with the theory that your doctor, your banker, and your insurance agent were your friends, and this was very comforting. He certainly led you to believe that he was your friend for sure.

Gary gave me—that's his name, if I may refer to him personally—they delivered my policy and all was well and good and I felt very comfortable with it.

Time went on and he would call me from time to time and want to know if I was receiving my Medicare benefits. I'd been going to the doctor and had a lot of problems at that time. He offered to pick them up for me and send them into the insurance company. He was truly my friend, he was helping me all the way.

Then the next time he came, he said, I think we'd better change this because it needs updating and there is better and new companies coming on the market all the time, so that's how this got started.

Well, to get down to the reason that I'm here is because the DA's office had filed a suit—this from Santa Cruz, CA—against the Bedrossian Insurance Agency for selling people like me too many health policies.

This is what happened. He gave me a policy, then he'd come back 3 months later to update it. He'd say, well, this is no longer the best there is and I think you should have the best.

By this time, him coming to my home regularly and helping me with my benefits and such, he was just like one of the college students that I'd worked with for 10 years as Assistant Dean of Students at the University of Oregon. I enjoy young people and Gary was a young man. He was very pleasing, I was just like a grandmother to him almost.

He would bring his little boy with him. He had been married and divorced—a very down home sort of attitude. He would always want to use the bathroom, do you have a cup of coffee, and very at home in my home, and I was glad to have him. He was good company.

Time went on over a period of 4 years, it got more so and more so. He was selling me more policies, they were overlapping constantly and it got so complicated that I thought I needed a secretary at times by sending in to the various insurance companies.

Finally, the last time that he came to my home, he said I should have a nursing home policy. He said that I was well above the average age for living and I would probably need to be in a nursing home at some time in the future and the time to do it was before you needed it.

I didn't want it. I said, I don't need this, Gary. I really don't want the policy. He said, this is a new one; it's just in California and one of the best we ever had. Well, I bought the policy but reluctantly.

It got to the point where I really didn't enjoy having him come anymore. It was just always the high-powered pitch every time he came.

After he sold me that policy a day or two, I learned about a counseling center that we had about insurance, so I began to seek them out. Prior to that, I had already cancelled my check or had stopped payment on my check because I just wasn't happy with that at all.

In the meantime, I did seek some counseling. It wasn't easy to find because the program in Santa Cruz at that time was quite new. Fortunately we have people in our area who are excellent people to work with and they are doing a marvelous job, but at that time in 1986, it was in its infancy and they weren't too easy to find.

Anyone who was infirm or unable to seek help would probably not ever find them or have found them at all. I felt very fortunate.

Then I learned that these abusive practices were going on in other areas as well and all over the place there in Santa Cruz, so I never saw Gary anymore after that. He kept calling me—he still calls me.

The CHAIRMAN. His name is Kinchelow, is that right?

Ms. BLACKBURN. Right. He still calls me. I received a Christmas card from him. He doesn't quit and he's always your friend. If I see him in the grocery store or anyplace, you'd think it was old home week.

The CHAIRMAN. Did you ever have a claim against any of those policies?

Ms. BLACKBURN. Oh, I received a lot of money. You'd think I was in the business of collecting from the insurance companies. Of course that was not my——

The CHAIRMAN. So they were not fraudulent policies?

Ms. BLACKBURN. Oh, no, he was doing nothing illegal. It was just very poor business practices. I think the blame lies with these insurance companies that train these young men. Here was a brilliant, extremely articulate young man, very bright and very knowledgeable, knew the insurance business inside and out.

Yet, here he has been trained to use his talents in such an abusive manner. I think it's a disgrace. Thank you, Senator.

[The prepared statement of Ms. Blackburn follows:]

CHARLENE BLACKBURN

TESTIMONY BEFORE THE UNITED STATES SENATE SPECIAL COMMITTEE ON AGING

MARCH 7, 1990

My name is Charlene Blackburn. I will be 80 years old next month. I am a native Kansan, now living in California. I attended Washburn University in Topeka, Kansas and became Assistant Dean of Students at the University of Oregon.

In 1982 it began. By 1986 I had 14 different insurance policies. Some were repeats, but for the most part these policies were the result of 14 different sales between 1982 and 1986. I was spending $3000 a year in premiums.

I guess it all began when I realized that Medicare needed to have a supplement to cover expenses. I had had some illnesses, and I was looking around. I had been in the hospital for surgery. It was terribly expensive and when you get a bill like that, it is very scary. I was extremely anxious to have some insurance. I had lost my husband and had a lot of business transactions, and other things to take care of. I got a card in the mail. It arrived at a good time. It looked extremely official, like it came from the government. I responded to the card and checked a box. It indicated, if I remember correctly, that an elderly person representing seniors in my community would come talk to me.

This was a whole new thing, I'd never had supplemental insurance. A Mr. Campbell came to talk with me. He was a nice looking, white-haired man, quite elderly. He was here twice. He came and sold me a Medigap policy and I thought I was all set. But, when he came a second time, I purchased a second policy. He had another insurance agent with him, and introduced me to him. From then on I never saw the elderly man again.

My new agent, Gary, was very aggressive and smooth talking, but very appealing. He was almost like a son to me. I liked him. He had beautiful manners, something that an elderly lady would appreciate. He would call me by my first name. He gave the impression that he was taking care of me. He said, "I'm going to send your Medicare claim forms, and make sure that you get what you need." He was very willing to help me in any way he could.

Not only would Gary send in my claim forms, but he often came by to tell me that a policy needed updating. He gave me the impression that he was trying to keep me with the best insurance. He had my confidence.

A pattern developed. He would sell me a new policy before my first one expired, evidently to avoid any time periods of no coverage during the waiting periods. That's the pattern that developed. It finally worked out that I was being insured by 3 or 4 different policies at one time.

Whenever Gary would do a favor for me, he would come to the the house. That would open the door for him to make another sales pitch. At that time, I had plenty of money. It got to the point that when he came, I knew he was going to sell me something.

The last time he came, he tried to sell me yet another policy. It was expensive, but he said "it is the best." I told him I don't want it, I don't want to pay that much. He said, "you'll be sorry" -- so I bought it. But after he left, I changed my mind and cancelled the policy. I wasn't angry, I just had to be firm with him.

At one point Gary said, I'm going to take you out of this company, their premium is doubling. That is when I became suspicious. I noticed that the premium had not doubled. That's when I went to senior legal services to get some help.

People today don't know where they can go to get information on supplemental policies. It is difficult, if you are infirm, and have a hard time getting around. One person in my neighborhood purchased 29 policies. And I thought I was naive for purchasing 13 policies. Fortunately, under the guidance of some very helpful people, I quit purchasing policies from Gary.

Gary did nothing illegal, but it was poor practice and poor merchandising to have a client paying for more than two policies at the same time. I became very angry with the insurance company that trained him. He had some really "good" training.

I testified in the Bedrossian Case which was a suit brought by the Santa Cruz County District Attorney's Office against the Bedrossian Insurance Agency. My agent, Gary, represented himself in the suit. He wanted to do his own defense. That was his downfall.

In court, after he started bearing down very hard, I said to him, "Gary, you are talking to me now just like you did when you were trying to sell me an insurance policy." He just refused to give up. I still receive phone calls from him, and he sends me Christmas cards.

The **CHAIRMAN**. Thank you very much.

I have all of the policies that you bought from Mr. Kinchelow here and it is a goodly number of policies, I might say.

Ms. **BLACKBURN**. Thirteen.

The **CHAIRMAN**. We tried, to the best of our ability, to sort of get an idea and it looks like Mr. Kinchelow probably made somewhere around $10,000 in commissions just off you.

Ms. **BLACKBURN**. Probably more than that.

The **CHAIRMAN**. If you see him next week in the grocery store, you might ask him to buy you a cup of coffee or something like that.

Ms. **BLACKBURN**. No, I don't want any more of that.

The **CHAIRMAN**. Gentlemen, if we could, let's go to our next witness and then there may be questions from our colleagues here, Ms. Blackburn.

We have a couple of our colleagues who have joined us. Senator Simpson has joined us and Senator Graham has joined us. We appreciate their presence with us. By the way, Senator Simpson, we heard from Senator Graham's fine constituents a moment ago, courtesy of video. Senator Graham, I am sorry you were not here. He is from Clearwater and we will tell you about him a little more.

Senator **GRAHAM**. You have him captured both figuratively and literally.

The **CHAIRMAN**. He said to tell you hello. He wants to come up here to sell you a Medigap policy. [Laughter.]

Senator **GRAHAM**. I am afraid he has lost his civil rights.

The **CHAIRMAN**. Ms. Hibbard, we appreciate you coming and we would love to have your statement.

STATEMENT OF LOIS HIBBARD, RIVERSIDE, CA

Ms. **HIBBARD**. My name is Lois Hibbard and I came from Riverside, California. I am 92 years old.

When the HICAP representative asked me if I would come, some of my friends said, you're crazy to go on a trip that long by yourself but I felt that after all, it's so important that I do anything I could to help advance the organization. That's why I am here.

Maybe about 4 or 5 years ago, I came from Long Beach and moved into a retirement home at Riverside, California. Soon after I came, I thought I should carry some insurance. My best friend introduced me to her insurance agent and assured me he was a good, honest man.

For several years, I carried Standard insurance with him for medical reasons and Standard paid off okay. By this time, I was beginning to be a little shaky about walking. At our home, the second floor is hospital and the third floor is home care where I would have to move if I had to have a walker.

I thought, well, I'd better get some insurance that will cover me when I have to move because that's going to be about $250 more a month, so I contacted my insurance agent and told him my problem. He sold me this policy of American Integrity.

After a few months, I was beginning to wonder—I had to pay $1,300 a year, plus $200 and something a month because I was past 90 years old.

In a few months I was getting a little more shaky and I was beginning to wonder, wonder if that policy really will cover me if I have to move to a more expensive floor. Our current event teacher at one time introduced some people from HICAP and said they would investigate any policies that people had that were endowed.

When I got in touch with Cathy, she looked over my policy and finally to me, no, it wouldn't cover me on third floor. It would payoff a little bit for skilled help but not really enough to pay for the policy.

When my doctor gave me orders to move to third floor because I was too shaky to walk—he was afraid I'd fall and thought I should have a walker and some help—so then I contacted my insurance agent because he had told me—I said, what do I do now if I get to where I can't walk. He said, call me and I'll come over and take care of it.

I called Mr. C and he came over. I explained the situation, that my doctor had already moved me to third where I could get help and use a walker, but I said, I've heard your policy won't cover me.

We argued a little while and he said, well, I sold you the right policy and I said, no, you didn't, they won't accept the policy here. Finally, he admitted it and he said, I'll tell you what I'll do—see, I'd pay $1,300 for it—he said, I'll give you $100 a month until I get it paid for and I'll pay you out of my own pocket.

Well, $100 a month for 13 months, I didn't know whether I was going to last that long or not, so I didn't accept it. I got in touch with HICAP, Cathy, and we started fighting back and forth, friendly.

Finally, he said, what will you take to not bring suit against me? I said, I want my $1,300 back, so he finally agreed that he would give me $1,300. He said, I'll give you $700 and something now and I'll pay you next week, $500 and something, enough to make the $1,300, which he did.

He said, rather than have you bring suit against me, and have a blot against my work, he says, I'm doing this out of my own pocket.

I don't know where he got the money, whether he got any back from the insurance company or what, but he satisfied my demand and gave me the $1,300. So that was a happy ending, I guess, to a bad experience, but a happy ending.

[The prepared statement of Ms. Hibbard follows:]

Mrs. Hibbard
March 7, 1990
Insurance individual's name was altered to preserve their privacy

Pg 1	Chronological listing of policies bought by Mrs. Hibbard
Pgs 2-4	Compilation of events based on documented statements made by Mrs. Hibbard.
Pgs 5-14	Mrs. Hibbard's hand-written statements

DATE	COMPANY NAME	TYPE	PREMIUM	Commission Rate*	Earned
1/3/86	American Integrity	Med Supp	886.50	x .6	531.90
2/11/86	Provider's Fidelity	Nursing Home	1245.00	x .6	747.00
1/10/87	Standard Life Ins	Med Supp	1377.00	x .6	826.20
1/8/88	Standard Life Ins	Renewal?	1377.00	x .2	275.40
3/4/88	First Farwest	Hosp. Indemnity?	1215.00	x .6	729.00
1/?/89	Standard Life Ins	Renewal?	1377.00	x .2	275.40
4/19/89	American Integrity	Skilled Policy?	795.55	x .6	477.33
4/19/89	American Integrity	Hosp. Indemnity	737.00	x .6	442.20
3.25 years	8 Policies	Total Money Spent	9,010.05		4,304.43 Estimated Earned Commission

* Estimated commission percentages reflect 60% commission for first time policies compared to 20% commission on policy renewals.

July 1989

I first met Mr. C in 1985 when I first came to Plymouth Towers. My best friend introduced me to him. She said they had carried insurance with him for a number of years. I bought from him prior to 1988. In January 1988 I bought a policy from Standard Life which covers medical.

In April of 1989 I spoke to my insurance agent, Mr. C, about not being able to get to the dining room on my own. I am presently in Independent Living and would have to move to Home Care Dept. (custodial care). I wanted to be sure I had an insurance policy that would cover this kind of care. Mr. C showed me a policy and assured me that it would cover this kind of care and I would have to pay extra because I am 91 years old. I did not need skilled care but I might need some help in walking places. I asked him if I had to make this change what should I do and he said, "you are covered" and to call him.

Each time I bought insurance, he took me to the bank to give him a check. I can't see well enough to read the print on policy so I trusted what he told me.

My name is Mrs. Lois Hibbard

I am 92 years old and I live in Plymouth Towers which is a senior housing complex in Riverside, California.

I used to work as a file clerk in Washington during World War I. I married and I stopped working. When World War II came, my husband and son were in the military, so I went back to work as a hospital aid in Downy, California until I retired 15 years later.

Between Jan. 1986 and April of 1989, I bought 8 insurance policies from my insurance man, Mr. C, for a total cost of $9,010. When I bought these policies the type of coverage was misrepresented so that I thought I had coverage for Home Care or custodial care when in fact I did not.

This was brought to my attention by a Riverside HICAP counselor after I had attended a community education meeting where I live. During July and September of 1989, I wrote to the HICAP program . Many months have passed since then, so in order to keep the details as I noted them in my correspondence, I would like to read a condensed version of my story which is provided to me by the Riverside HICAP office. You have available to you an uncondensed, typed statement as well as copies of my handwritten statements.

July 1989

I first met Mr. C in 1985 when I moved to Plymouth Towers. My best friend introduced me to him. They had carried insurance with him for a number of years. I bought Standard Life Medicare supplement for 3 years from him prior to April 1989. A few times when I bought insurance, he took me to the bank to give him a check. I can't see well enough to read the print on the policy so I trusted what he told me.

In April of 1989, I expressed my concern to Mr. C about moving from Independent Living to Home Care (custodial care) because I was having trouble walking unassisted to the diningroom. I wanted to be sure I had an insurance policy that would cover this kind of care. Mr. C showed me a policy and assured me it would cover this care and I would have to pay extra because I am 91 years old. I asked him what to do when I had to make the move and he said, "you are covered" and "to call me."

Now I find that this policy, American Integrity, does not cover Home Care it only covers skilled nursing care and this would not do me any good. I feel that Mr. C wasn't being honest in selling me this policy. I am registering a complaint as I feel he did not sell me the type of coverage which he said he was selling me. I feel very disappointed and upset about what happened.
I hope that you can help me with some type of action.

Signed and written by Lois Hibbard

P.S. I almost didn't take out this policy but Mr. C said how much money I would spend without this policy so I bought it.

September 3, 1989

Mr. C came and read the doctor's orders for me to move to the 3rd floor and get a walker. On the 3rd floor, I will get assistance in walking and other things on account of an imbalance and pain in my hip. Mr. C said my policy was for skilled care and the policy wouldn't pay.

I asked him why he sold me this policy when he must of known that wasn't the kind of help I needed. After knowing me several years and helping me walk to the car and the bank and after I had asked him if I got to where I couldn't walk to the diningroom and had to move to the 3rd floor he has said "call me" and everything would be taken care of.

Now he says he thought I would go to the 2nd floor which is skilled care and my policy wouldn't pay for the kind of help I need. I can't understand why he didn't know that when he sold me the policy.

He asked me what I wanted, I said "My $1300 back." He said he would pay me $100 a month out of his own pocket if I wouldn't bring suit against him and cause a blot on his record whether he won or lost.

We had a little friendly conversation and he said he would see me again in a few days. He called me Spetember 5, 1989 and said he had the flu and wasn't able to come over today but will call me the next day.

September 8, 1989

Mr. C came yesterday and gave me his personal check for $727 saying he had gotten it back from the insurance company. I accepted it. He is to come next week with the remainder of $1300. Either it will be from the insurance company or his personal check. Then, I will have my $1300 back which is what I want.

Lois Hibbard

September 15, 1989

Mr. C gave me a (personal) check for $573. This, with a previous check of $727, makes $1300 he has returned to me. I am satisfied with this as it is the amount paid by me for the policy with company #1 which turned out to be unacceptable with the retirement home where I live. I feel that Mr. C has been fair with me.

Lois Hibbard

The **Chairman**. This particular agent, I think, made about $4,300 in premiums from the policy that he sold you, so don't feel bad if he paid you out of his own pocket. He had it to pay you back.

Now, let me do this. Let me ask my colleagues if there are any questions for either of these fine witnesses this morning? Senator Simpson; Senator Graham. Senator Kohl now is with us; we appreciate him being here.

STATEMENT OF SENATOR BOB GRAHAM

Senator **Graham**. Mr. Chairman, I wish to express my appreciation for your holding this hearing, representing a State as you do with large numbers of persons who are in the age and circumstance that they are vulnerable to be preyed upon by purveyors of fraudulent policies. I particularly appreciate your holding this hearing today.

[The prepared statement of Senator Graham follows:]

BOB GRAHAM
FLORIDA

Bob Graham

United States Senate
WASHINGTON, DC 20510-0903

OPENING STATEMENT OF SENATOR BOB GRAHAM
UNITED STATES SENATE SPECIAL COMMITTEE ON AGING
Hearing on Medigap Insurance
March 7, 1990

Good morning. Chairman Pryor, I commend you for convening this important hearing. I share the Chairman's concern regarding marketing and sales abuse and lack of information for seniors in the supplemental insurance or Medigap market. As a Senator from the State of Florida, representing three million elderly Floridians, I am pleased to participate in this hearing.

Following the enactment of the Medicare Catastrophic Coverage Act, in 1989, the premiums for Medigap insurance policies rose substantially, at a rate between 10 to 133 percent. According to the GAO, this year, premiums are expected to increase from 5 to 50 percent in response to the now-repealed 1988 catastrophic law.

Indeed, approximately 40 percent of the 20-some million Medicare beneficiaries purchases supplemental insurance. As the primary purchasers of such insurance, the elderly are affected by a serious problem, lack of comprehensive and factual information on Medigap insurance policies. High-pressure marketing and sale's tactics make the elderly susceptible to the purchase of duplicative and sometimes unnecessary supplemental insurance.

In testimony today, we will hear from Mr. Ed Kodish. Mr. Kodish, a former insurance agent in Florida, is serving time in a state prison on charges of grand theft and exploiting the elderly. He was trained in this practice by an insurance company. I encourage the Florida Department of Insurance and the state Attorney General's office to continue to protect the elderly through the investigation and prosecution of such offenders.

In Florida, the over-65 age group is growing almost twice as quickly as the general population. The Florida Department of Insurance offers these senior consumers free seminars on Medicare supplemental insurance. Florida's seniors appreciate and utilize this information, however, the seminars are scheduled infrequently and only at the request of senior citizen groups throughout the state. Not only do seniors need access to thorough information, but they need to know where to go to get that invaluable data.

I am committed to working with Chairman Pryor on legislation to provide states with grants for health insurance counseling and assistance for Medicare beneficiaries. The Chairman's bill would emphasize the use of trained volunteers for counseling efforts. The Senate recently passed the National Community Service Act, and, at this time, it is appropriate to encourage volunteerism.

I look forward to hearing from our panel of distinguished witnesses today. Their considerable experience and expertise will help us address these problems and provide reliable information on Medigap insurance to our nation's seniors.

The Chairman. Thank you, Senator Graham. Senator Simpson.

STATEMENT OF SENATOR ALAN K. SIMPSON

Senator Simpson. Mr. Chairman, I, too, would enter my statement in the record. I appreciate your having this hearing. You are a very attentive Chairman and this is another evidence of that.

Mr. Chairman, we do this almost every year and it is important that we do. We must remind people that there are many, I think, good, attentive, and caring agents, but there are also some bad ones. Every year the industry comes to us and says "You are right. We are going to take steps to root these people out and this is our duty. We will clean the bad apples out of the barrel, don't you worry." But it never happens.

I think that is what I am interested in hearing the witnesses say as we hold these hearings: when will they do this? I think you are, Mr. Chairman, putting the industry on notice. This is getting close to the last hurrah. This is the final sweet kind of notice to the abusive Medigap companies and let it be known as that. We recognize that there are good companies, attentive ones and ones that are very responsible, but this is just the same old stuff.

They come and tell us the same old stuff every year. The Catastrophic repeal is really what triggered it this trip. "You will be out in the street, you will be eating out of garbage cans now that they've repealed the Catastrophic Health Care." That is what the insurance salesmen are using to frighten older people into buying their policies. That was a really good lick for them.

For me, this is a final notice to the bums. The good ones don't have to worry.

[The prepared statement of Senator Simpson follows:]

Aging Committee Hearing "Abuses in Marketing Medigap Insurance"

Mr. Chairman, I think it is just appalling that we should even have to have this hearing today. I reviewed the material that your fine staff distributed earlier this week—it was chock full of examples of the sort of BS that some unscrupulous insurance agents are capable of if it'll get 'em a commission. They prey on the fear and the vulnerability of frail older people. They sell them garbage, and they do it over and over again, with manipulative techniques that I find offensive in a profoundly moral way—and a legal way.

What's even more disturbing Mr. Chairman, is that this is not the first time that we've had a hearing like this. In fact, it seems that every year—or almost every year—we have a hearing to examine how the elderly are being treated in the insurance game. And every year the industry—which we must remind people is populated with even more good, competent, caring agents than bad ones, every year the industry replies you're right. We'll take steps to root the bad apples out of our own band. Don't you worry!" But it hasn't happened. Has the situation even improved? Maybe our witnesses will be able to tell us that.

In years past we've threatened tough, tough regulations to curb abuses in the marketing of Medigap. But the industry has howled in protest and has promised to do all the right things to clean itself up—so we backed off. But Congress is fast losing patience with this kind of thing. I know some of our colleagues are determined to put all manner of shackles on the Medigap companies, so enraged are they at continued tales of abuse and deceit and fraud. I don't think we should do that, yet, Mr. Chairman, but I do think this hearing ought to be a kind of "final notice" to the abusive Medigap companies.

Mr. Chairman, let me conclude by saying that I commend the approach that you have taken in your legislation to address this issue. Yet I am a believer in the doctrine of caveat emptor—buyer beware. But "caveat emptor" assumes that in the marketplace, buyer and seller are both rational creatures with access to the same information, though one may have it and the other not. The point is, the other can get it—neither is at a disadvantage in the transaction. I think that doctrine may not apply so well to the Medigap insurance industry—I think that caveat emptor may be too much to ask of frail, frightened older people when confronted by an insurance agent who is telling them that their existing coverage is worthless. They are at a real disadvantage. They do not have the means to compare their coverage with whatever he or she is peddling. They do not have access to the information that would make such comparisons meaningful. The chairman's bill would give them a resource to draw upon—would put the elderly in a better position to make informed decisions about buying insurance. It would, to use a tired "old phrase," "level the playing field" between buyer and seller.

I still believe that insurance regulation and all that goes with it belongs at the level of the State Insurance Commission. I do believe that. And for that reason, I haven't made up my mind whether to cosponsor the chairman's bill. I'll decide after I review the testimony from today's hearing. But I do think you're on the right track—I like the approach very much (just wish the State's had thought of it). I hope the industry pays special heed to this the last, final notice.

The CHAIRMAN. Thank you, Senator Simpson. Senator Cohen.

Senator COHEN. Mr. Chairman, I would like to just direct a question to Ms. Blackburn. The terms of the nature of the relationship that you had with this particular agent and insurance company are a little bit unclear, Ms. Blackburn.

On the one hand, he was very appealing, charming, aggressive, extremely aggressive, persistent. I just looked at the list of policies he sold you and the timeframe in which he sold them to you. It is quite clear about every 4 or 5 months, he was back with one or two policies in addition.

Then you indicated at the end of your testimony that in fact you had received all the money that was provided under the contract itself, so you had no question about the legitimacy of the insurance company or their policies.

He did not tell you that a policy would give you coverage that it would not, in other words, a fraudulent misrepresentation. He did not sell you a policy that wasn't necessary. It is just that he was basically harassing you with high-powered tactics. That is what I gather from your testimony. Is that your understanding of the situation?

Ms. BLACKBURN. That's true. That is it exactly.

Senator COHEN. Did you testify against the insurance company in a legal proceeding brought against it?

Ms. BLACKBURN. The same story that I'm telling you here today. It was a matter of his poor business practices, the harassment was the problem. I wasn't trying to collect dollars from insurance companies.

Senator COHEN. The nature of the problem is not simply that we have young, aggressive insurance agents who are preying upon the elderly, taking advantage of and exploiting their fears and anxieties. In some cases, these agents are actually selling them policies that are unnecessary, that are duplicative, that don't provide the claimed coverage. These companies not only employ high power tactics, but sell policies that do not live up to the contract.

Ms. BLACKBURN. That is true.

Senator COHEN. So we do have a fraudulent situation in a number of cases.

Ms. BLACKBURN. It appears so, yes. My main quarrel was that he was a young man. He had all the abilities to be a fine insurance salesman. He was trained very, very badly by this insurance company.

Senator COHEN. As we saw from that television tape, there are probably a lot of talented, young, aggressive men out there.

Ms. BLACKBURN. He was young, he showed good breeding, he had beautiful manners. He was a very nice looking young man.

Senator COHEN. Thank you very much. That is all I have, Mr. Chairman.

The CHAIRMAN. I know Senator Cohen's general line of questioning and I know exactly what he was meaning. I would like to say, if I might, sort of help in a response from Ms. Blackburn to Senator Cohen.

Many of the elderly people that we interviewed in attempting to get ready for this hearing were somewhat embarrassed and sort of humiliated to come forward and sit here like the two of you have so graciously done and sort of admit that they had been taken.

Ms. BLACKBURN. True.

The CHAIRMAN. You talked about your generation, what you expected of certain individuals. Also I assume in your generation, there was also that feeling of great pride that you didn't like to get out there to admit that someone had sort of hornswoggled you.

Ms. BLACKBURN. That's true.

The CHAIRMAN. We appreciate the two of you coming.

Ms. BLACKBURN. My friend said to me, how can anybody be so naive.

The CHAIRMAN. By the way, don't feel so guilty about not knowing what your policies cover. I know that Senator Grassley mentioned this a moment ago in his opening statement. I also mentioned that same story to the Finance Committee hearing last month.

I was on the Pepper Commission which dealt with the issue of long-term care, a very controversial report we issued on Friday. It took us 9 months and we just passed it by one vote, 8 to 7, which is beside the point.

Congressman Stark gave all of us on the Commission—here we were the so-called experts in the Senate and the House, 15 of us and three appointees by the President on health coverage, health care and all of this, and he gave us a test, the 15 of us, as to what our particular policies covered. All of us flunked, so we don't know.

There is massive confusion out there, not only here, but out across the country.

Do we have further questions, of the two witnesses, from Senator Graham or Senator Kohl?

Senator WARNER. I would, Mr. Chairman.

The CHAIRMAN. Yes, sir, Senator Warner.

Senator WARNER. Mr. Chairman, if I may. First, I join in thanking you for coming forth; it is not easy but both of you are very proud persons and I think at this age you look out on the world to be a little kinder and gentler towards you, and in fact it is not.

If I might speak personally for a moment, I was privileged to have a mother to live to be 98 years old. I worked with her in the latter part of her life, as did my brother, so therefore I had a modest amount of, you might say, on-the-job training. Not only we worked with my mother, but persons who shared the nursing home with her. We got to be sort of one big family.

What concerns me, Mr. Chairman, is that we have to recognize that this age group is preyed upon by a variety of individuals, not just the insurance industry. There are other problems.

On the insurance issue, I join with my colleague, Mr. Simpson, I am sure many, many companies, the vast majority of them, wouldn't permit this type of thing, do not permit it and counsel their agents not to overstep that gray line to take advantage.

Should we not look at the legislation—which I have joined you in—as a part of a larger thing to counsel persons on a variety of problems that they encounter at this point in their life? Should we not look at it as a part of the Older Americans Act umbrella?

We have the ombudsmen who act to advise the elderly on nursing homes and those issues, but my concern is that our society is moving towards one stop, take care of everything, and we might be setting up many stops for the elderly to have to go here for insurance, here for nursing homes, and here for other types of advice.

We might better try and pull this all together so that the counseling services cover a number of issues.

My question to either witness is, are there not other areas where you are somewhat apprehensive and fearful that you could be subjected to persons that want to take advantage of you?

Ms. **Blackburn**. Are you asking me the question?

Senator **Warner**. Yes.

Ms. **Blackburn**. I think the thing that has to be taken into account, one thing for sure, is that there are—I've discovered this since my problem was more or less resolved— lots and many, many elderly people who don't leave their homes. They are lonely, a lot of people are. Even in retirement communities you find lonely people who stay to themselves.

These people are welcoming these insurance agents along with other people who want to——

Senator **Warner**. But it is not just insurance, there are other problems?

Ms. **Blackburn**. It's not just insurance, there are other problems, I'm sure, but this is certainly one that highlights my experience.

Senator **Warner**. I have no question about that. You very vividly portrayed it.

Ms. **Blackburn**. It's been a tremendous learning experience for me, thank goodness, that I was well enough to handle it but at the time I was very vulnerable.

Senator **Warner**. If we set up some system whereby you were given the opportunity to have counseling, would it not be better if that counseling would cover say four or five subjects as opposed to just insurance?

Ms. **Blackburn**. Possibly so. I hadn't thought of it in those terms, but I am sure that's true.

Senator **Warner**. Ms. Hibbard, do you have a view on that?

Ms. **Hibbard**. I feel that I have HICAP to thank for getting my $1,300 back. Otherwise, I am sure I would have lost it completely.

Senator **Warner**. I thank the Chair.

The **Chairman**. Thank you, gentlemen. Are there any further questions for this panel? Senator Heinz?

Senator **Heinz**. Mr. Chairman, I wasn't here when you showed the tape but I am familiar with it. I know the case histories of Ms. Blackburn and Ms. Hibbard.

What this tells me is, as excellent a job as the committee's investigators and the Chairman have done, I think what we have found is only the tip of the iceberg. I think we have only scratched the surface.

I would like to offer, Mr. Chairman, that the minority staff and the majority staff join forces to launch a really comprehensive investigation of these practices; to go down to Florida and checkout not only who we saw on the tape but do some additional eavesdropping, if you will.

When I was privileged to Chair this committee, I was very fortunate to have a very skilled and competent investigatory staff. At the time, the Federal Government was overreimbursing for pacemakers. We sent our two investigators underground for 6 months.

They set up a clinic in San Francisco, a fake clinic, and another one in New York State, and pacemaker salesmen came in to explain how these two investigators who were posing as people who wanted to set up a cardiac clinic could make millions of dollars and "all it was going to cost them was stamps."

We got it all on video tape. We had several totally unscrupulous salesmen right there explaining how you could rip off the Federal Government. Out of that came a major series of prosecutions as well as some major changes in the way Medicare reimbursed.

We have a very parallel situation here, only it is not the Government that is being ripped off, it is you. We need to have a clear understanding of the extent of the problem and we need to redouble our efforts.

At the beginning of the hearing, Mr. Chairman, I said I thought at the minimum, we ought to pass your legislation.

I don't know what the maximum ought to be but I do believe, based on the excellent work that you have done, that your staff has done, that there is far more we need to do to expose what is a national scandal. All of us need to not only to understand the problem, so more knowledgeable consumers can begin protecting themselves, but also to lay the foundation for some major consumer protections which clearly are now absent.

Senator **Warner**. Mr. Chairman, if I can make one observation. It seems to me we have a parallel responsibility not to inject fear and fright and proclaim here how pervasive this situation may be.

I would like to start with the assumption that most companies are responsible and that these incidents, although very serious, are somewhat isolated. If we are going to launch forward as a Congress or as a committee to look at this, just think of the hundreds of thousands of people that may be gaining knowledge from this hearing who suddenly begin to think that everything around them is going fraudulent. I suggest we approach this carefully and in a balanced way.

Ms. **Blackburn**. May I say something? You see, the insurance agencies carry so many different company policies. They represent dozens of companies. I don't know how many, I have no idea, but I had a good number of them, I can tell you that, and there were a lot of people who had a lot more policies than I did.

The Bedrossian Insurance Agency represents a lot of insurance companies. I am wondering if they are aware of what they are doing out there. I just wonder if they know how they are being used.

The CHAIRMAN. We appreciate that very much. Any further questioning of our two witnesses?

We want to thank both of you today for appearing. We know that you've come from a long distance. We want you to know that you have performed a very, very worthy service in doing this. Thank you both.

Ms. BLACKBURN. Thank you.

Ms. HIBBARD. Thank you.

The CHAIRMAN. We will call our next panel now, Mr. John Hildreth, Mr. Ronald Gaiser, and Mr. Ron Taylor. It is my understanding that Mr. Gaiser was unable to be here this morning. I think I am correcting in saying that. Oh, he is on his way, so just leave his card there.

Let me tell our colleagues about these two gentlemen and then the third gentleman, Mr. Gaiser. Mr. John Hildreth represents the Consumers Union Southwest Regional Office from Austin. Mr. John Taylor is the Insurance Commissioner, accompanied by Carole Olson from the State of Arkansas. He is today representing the National Association of Insurance Commissioners.

In a moment, we will have Mr. Gaiser, a private attorney from Birmingham who will join the panel.

We will ask Mr. Hildreth if he would make his statement. I am going to use the light system. We do have a joint session of Congress that is going to occur approximately at 11:00. Some of our colleagues may have to leave before that.

Mr. Hildreth if you would sort of summarize your statement, we would certainly look forward to it. We will have some questions when you and Mr. Taylor finish.

STATEMENT OF JOHN HILDRETH, CONSUMERS UNION SOUTHWEST REGIONAL OFFICE, AUSTIN, TX

Mr. HILDRETH. Thank you, Mr. Chairman. I must confess some reticence to testifying after hearing your outstanding opening statement and that of the other Senators. I learned a long time ago not to mess with a good thing and it would seem the concerns expressed here are already responsive to the problems we know exist.

This committee's investigation does come at an appropriate time after repeal of the Medicare Catastrophic Coverage Act. There is widespread confusion and misinformation among the elderly making many of them vulnerable to Medigap marketing abuses.

The size of the market and the ineffectiveness of insurance regulation have led to numerous problems for elderly consumers in Texas and other States.

First, there is widespread misunderstanding about Medigap policy provisions. Second, many elderly consumers rely on the advice of insurance agents who intentionally or otherwise mislead elderly consumers in their purchase of Medigap policies. Third, many elderly send their names to lead developers for information about Medicare who in turn sell those names to Medigap agents.

The problem is pervasive but I will limit my comments today to some of the most insidious problems and some proposals to solve those problems.

Texas has the regrettable reputation of being home to several of the nation's lead developers. Lead developers generate leads or contact lists used by insurance agents to sell policies to clients.

Generally Medigap lead developers put out advertisements which offer information about Medicare similar to those that you have seen. We have collected numerous ads such as those that you have with you today and they are commonplace in the industry.

Language like this is quite effective. It generates leads and it does little to promote a fair market place for elderly consumers.

Due to the complexity of most Medigap policies, consumers are unable to effectively understand and compare policies and make intelligent buying decisions. This has led to reliance by Medigap consumers on either the recommendations of agents, or advertising, or both in making buying decisions.

This, in turn, has enabled unscrupulous operators to engage in twisting of policies and to promote the purchase of duplicate Medigap policies. Buying duplicate policies is wasteful, yet there have been many instances of duplicate coverage across the nation.

While the health insurance industry claims that these practices are on the decline, a recent survey by AARP indicates that 24 percent of the elderly have two or more private policies.

Several changes have been proposed to end the abuses in the Medigap market. We have supported initiatives which would standardize Medicare supplement insurance policies. Standardization limits the proliferation of Medigap policies and offers consumers the ability to make an informed purchase decision.

Consumers Union also strongly supports Senator Pryor's proposed legislation that would establish a grant program to increase senior citizen health insurance counseling programs across the country.

It is our belief that if you provide accurate information to consumers, then they can make wise purchasing decisions.

Twelve States already have established counseling programs. They've been extremely popular with senior citizens and very effective in educating them about their health insurance needs. Our Washington office is in the process of doing a survey of these programs.

Some of the preliminary findings are first, that all of the counseling programs are extremely popular. This popularity has been reflected by increased program budgets to allow the programs to reach more senior citizens.

Second, staff members and counseling programs are eager to both share their expertise with other programs and to discuss common problems with counterparts from other States. A network for such professionals would be extremely valuable.

Benefits to senior citizens of States with counseling problems programs are real. The anecdotes are there in terms of the amount of money that is being saved across the country from these programs.

Most of them are new. We believe the proposed legislation would help other States to establish these types of counseling programs to expand the number of citizens that could be reached. We support them and urge the committee to move forward with that legislation.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Hildreth follows:]

Consumers Union
Publisher of Consumer Reports

TESTIMONY OF JOHN L. HILDRETH,
DIRECTOR,
SOUTHWEST REGIONAL OFFICE OF CONSUMERS UNION

BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING
7 March 1990

Consumers Union* appreciates the opportunity to testify today before the Senate Special Committee on Aging. I am John Hildreth, director of the Southwest Regional Office of Consumers Union.

Consumers Union has been active in advocating on behalf of elderly consumers in the area of Medicare supplement, or "Medigap," insurance. Consumer Reports, a publication of Consumers Union, has investigated Medigap policies and abuses in the industry, most recently in June 1989.

Consumers Union has advocacy offices in Texas, California, and Washington D.C. These offices have worked for laws to protect elderly consumers from abuses in the Medigap market. Consumers Union's West Coast office worked for statutes requiring standardized policies. My office has also worked for standardization as well as controls on Medigap advertising and standards for agent conduct.

This Committee's investigation comes at an appropriate time. After repeal of the Medicare Catastrophic Coverage Act, there is widespread confusion and misinformation among the elderly making many vulnerable to Medigap marketing abuses. I want to share with the Committee the nature and magnitude of the problems in Texas and across the nation, how regulators have failed to protect the elderly, and why Consumers Union believes aggressive steps are needed now to correct these abuses.

The importance of the Medigap market is not in question. After repeal of the Medicare Catastrophic Coverage Act, elderly consumers could find themselves paying for expensive hospital and doctor bills. The possibility of having to pay catastrophic health bills makes Medigap policies a necessity.

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* Consumers Union of U.S. Inc., is a nonprofit membership organization chartered in 1936 under the laws of the state of New York to provide information, education, and counsel about consumer goods and services and the management of the family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service may be met, in part, by nonrestrictive, noncommercial contributions, grants, and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 4 million paid circulation, regularly carries articles on health, product safety, marketplace economics, and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

The size of the market and the ineffectiveness of insurance regulation have led to numerous problems for elderly consumers in Texas and in many other states: (1) there is widespread misunderstanding about Medigap policy provisions; (2) many elderly consumers rely on the advice of insurance agents who, intentionally or otherwise, mislead elderly consumers in their purchase of Medigap policies; (3) many elderly send their names to lead developers for information about Medicare, who in turn sell these names to Medigap agents; (4) and many of the policies sold are not a fair value because most states do not enforce the minimum loss ratio standards enacted by the Congress under the Baucus amendment.

Medigap Policies are not a Fair Value

Because the premium rates of Medigap insurance are not regulated in most states, the only way consumers are assured that Medigap policies are a fair value is their reliance on the enforcement of "loss ratio" regulations. Loss ratios measure the proportion of premiums taken in by a policy that are paid out as benefits to policyholders. Loss ratios measure the value of a Medigap policy; policies with high loss ratios are a better value than those with low loss ratios. According to a 1987 report by the General Accounting Office, the industry has performed dismally. Of almost 400 policies examined in the report, 64 percent had loss ratios below the standard required by the Baucus amendment.[1] Recently the GAO testified that 34 percent of commercial insurance companies selling individual Medigap policies had loss ratios below the 60 percent minimum loss ratio in 1988.[2] According to reports issued by the Texas State Board of Insurance, the industry's performance in Texas has been equally poor.

Lead cards and Medigap advertising

Texas has the regrettable reputation of being home to several of the nation's lead developers. Lead developers generate "leads," or contact lists, used by insurance agents to sell policies to clients. Generally, Medigap lead developers put out advertisements which offer information about Medicare. These ads may appear to be from the government, may use a misleading name, or may have a return address in Washington D.C. Often the D.C. address is only a drop box for a lead developer in Dallas. The lists, including names, addresses, and telephone numbers of elderly consumers, are sold to Medigap agents who use the lists to sell elderly consumers Medigap policies.

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[1] "1987 Loss Ratios of Selected Medigap Insurance Policies," General Accounting Office, April 1989.

[2] "Medigap Insurance: Expected 1990 Premiums After Repeal of the Medicare Catastrophic Coverage Act and 1988 Loss Ratio Data," Statement of Janet Shikles, Director, Health Financing Policy Issues, Human Resources Division, Before the Subcommittee on Medicare and Long-Term Care, Committee on Finance, United States Senate, February 2, 1990, p. 7.

Years of inaction by many state regulators gave unscrupulous advertisers and lead developers the impression that insurance regulators could not, or would not, act to stop deceptive advertisements. The Medigap advertising and lead developer industry expanded in Texas and in other states. Within the last several months Texas regulators have increased their efforts to require lead developer operations to comply with insurance regulations. While there has been some success, lead developers and misleading advertisers continue to be a problem.

Consumers Union's Southwest Regional Office collected numerous Medigap ads from newspapers and mailings. The advertisements show the flood of promotional material soliciting insurance the elderly receive. They also show the scare tactics used by insurance companies to increase sales of Medigap policies. Consumer Reports conducted an investigation of lead developers and misrepresentation in the Medigap industry. The article criticized the names often used by lead developers to mislead elderly consumers such as: Retired Persons Information Center; National Health Information Center; National Processing Office; or Consumer Referral Service Center, Medicare Division. Often advertisements use language which would worry any consumer. One lead card solicitation said, "Are you aware of the new changes in our Medicare system? These changes increase the amount you must pay for your personal health care."[3] Language like this is quite effective in generating leads, but it does little to promote a fair marketplace for consumers.

Medigap Agents and Sales Practices

Many of the problems associated with the Medigap market happen because of agent misrepresentations or abusive sales practices. Agent licensing and educational requirements are often quite lax. An underlying problem of aggressive sales practices is the agent commission structure. Medigap agents receive much higher commissions for new sales than for renewals. An agent may receive a first-year commission of seventy percent of the first year's premium, with a subsequent years' commission as low as fifteen percent. So an agent's incentive to get an elderly consumer to switch, or "twist," old policies for new ones is built into the system. However, while an agent gets a higher commission for a new sale, the consumer is usually subject to a waiting period of up to six months for pre-existing conditions. Because of confusion among elderly consumers about Medicare benefits in the aftermath of the repeal of the Medicare Catastrophic Coverage Act, many elderly are particularly vulnerable to unscrupulous agents. The NAIC recently took steps to limit the abuses caused by high first year commissions, and banned restrictions on coverage of pre-existing conditions on replacement policies. There is still uncertainty, though, about whether states will adopt the changes and enforce the new regulations effectively.

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[3] "Beyond Medicare," Consumer Reports, p. 386 - 7, June 1989.

Misunderstanding Policies and Duplicate Coverage

Fundamental to the problems in the Medigap market is the widespread lack of understanding of Medigap policies. In order for a free market to operate correctly, consumers must make informed decisions. However, Medigap consumers are not informed consumers.

There are many different Medigap policies available for sale to the elderly. Most of the policies vary because of insignificant policy provisions, but, because of sheer numbers, there is no way for elderly consumers to compare policies side-by-side. The way companies succeed is often not through selling fair-priced and well serviced policies; instead, it is with aggressive advertising and sales practices.

Due to the complexity of most Medigap policies, consumers are unable to effectively understand and compare policies and make intelligent buying decisions. This has led to a reliance by Medigap consumers on the recommendations of agents and advertising in making buying decisions. This, in turn, has enabled unscrupulous operators to engage in "twisting" of policies and to promote the purchase of duplicate Medigap policies. Buying duplicate policies is wasteful. Yet, there have been many instances of duplicate coverage across the nation. Some examples from Texas include:

-- A couple in their eighties was sold thirteen health insurance policies (according to Emory Walton, District Attorney, Eastland County, Texas).

-- A woman in Ennis, Texas was sold fifteen medigap, hospitalization, and other policies within a year's time at a cost of more than $10,000 (according to Kirkpatrick, "Insurance Scams Target the Elderly," Dallas Morning News, Feb. 14, 1988, at 1.

-- An elderly couple living only on social security income was sold six supplemental policies. The couple was so broke from paying for their policies that they had to get city assistance to pay for repairs to their house (according to George Davis, "Gapline" volunteer in Ft. Worth, Texas).

While the health insurance industry claims that these practices are on the decline, a recent survey by AARP indicates that 24 percent of the elderly have two or more private policies.[4]

Ending Medigap Abuses

Several changes to the Medigap market have been proposed to end the abuses in the Medigap market. Consumers Union has supported initiatives which would standardize Medigap policies. Standardization would establish uniform definitions for key policy terms and restrict the variations allowed for other insurance policy provisions (such as the length of pre-existing condition periods). In a standardized market, policy benefits could not vary from standard levels set forth in a "low," "medium," and "high" policy, which would range from less comprehensive to more comprehensive.

Since Medigap policies generally offer to pay some portion of what Medicare does not pay, the policies tend to differ because of insignificant policy provisions. Standardization limits the proliferation of Medigap policies and offers consumers the ability to make an informed purchase decision.

Consumers Union also strongly supports Senator Pryor's proposed legislation that would establish a grant program to increase senior citizen health insurance counseling programs across the country. Twelve states have already established counseling programs. These programs have been extremely popular with senior citizens and very effective in educating them about their health insurance needs. Our Washington office is in the process of doing a survey of these counseling programs. Some of the preliminary findings are:

-- All of the counseling programs are extremely popular, and this popularity has been reflected by increased program budgets to allow the programs to reach more senior citizens. The budget for Maryland's program, for example, grew from $44,000 in 1988 to over $170,000 in 1990. Program staff in Idaho, with a senior citizen population of 140,000, reports the need for counseling is overwhelming. Its staff recently grew from one to three, and would need to double to meet the demands for counseling.

-- Many states that do not have a counseling program are keenly aware of the need for such a program, and are searching for the expertise and the funds they would need to establish such programs. (The proposed legislation could provide just what they need to get the programs launched.)

-- Staff members in counseling programs are eager to both share their expertise with other programs and to discuss common problems with counterparts from other states; a network for such professionals would be extremely valuable.

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[4] "Consumer Awareness of Medigap Insurance: Findings of a National Survey of Older Americans," AARP, 1989, p. 10.

Benefits to senior citizens of states with counseling programs are real. A few anecdotes help to illustrate the success of these programs:

From Worchester County, Maryland (Senior Health Insurance Counseling Program):

> As a result of counseling, it was discovered that a woman had duplicate coverage, and she was advised to keep only one Medicare supplement insurance policy, resulting in a savings of almost $2000 annually.

From Idaho, (Senior Health Insurance Benefits Advisers):

> Program volunteers referred a man to the insurance department's investigator's office, whose efforts resulted in a refund of $11,000 to the man who had owned duplicative policies.

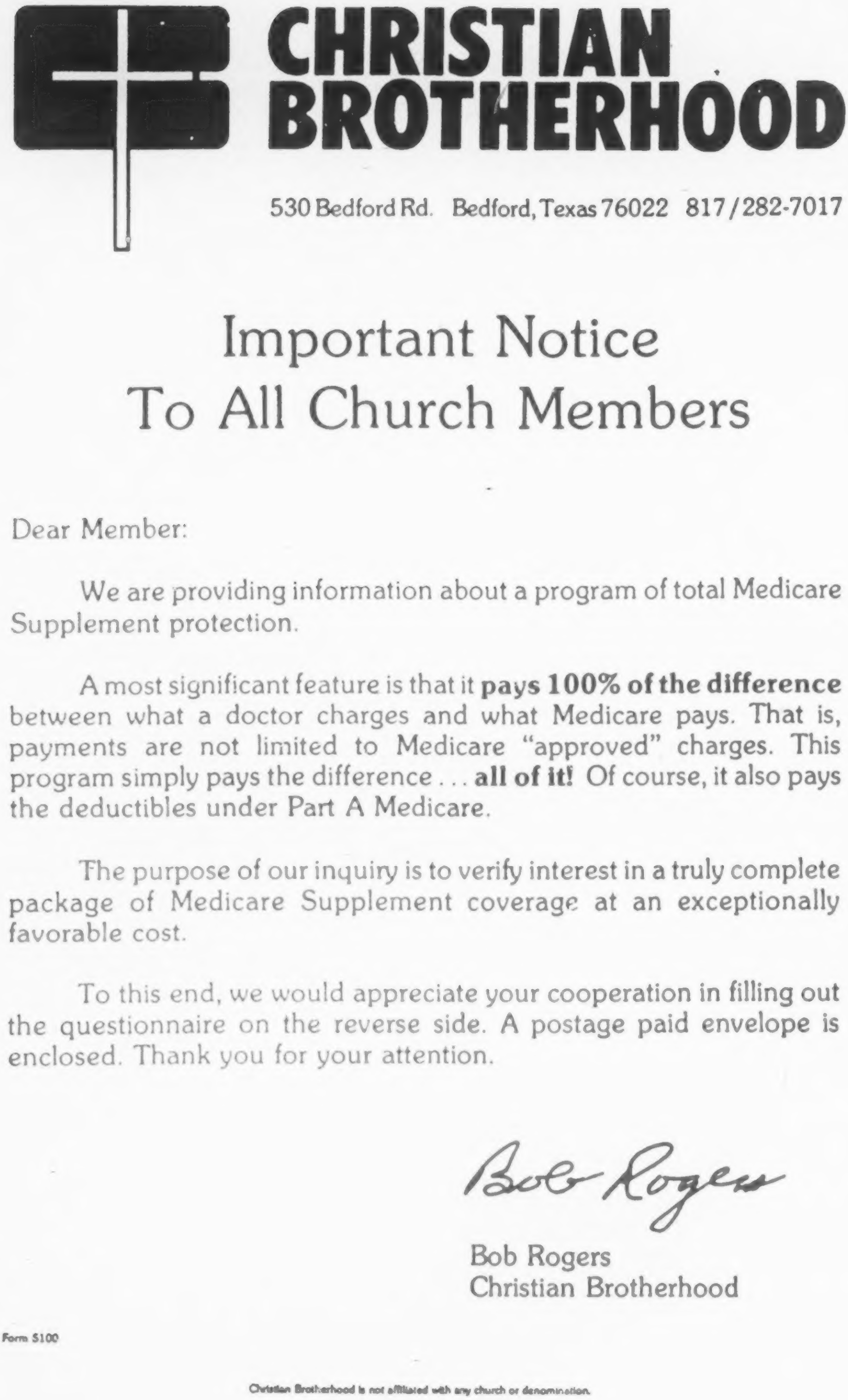
From California, (Health Insurance Counseling and Advocacy Program):

> The local HICAP project was contacted by a client because she had been sold a nursing home insurance policy by an agent from a well-known insurance agency. The agent had come to the client's house unannounced but holding a card she had mailed several months earlier to a "consumer alliance" group. This group was a front for an insurance agency. This "consumer alliance" has now been outlawed from mailing in California by a cease and desist order from the California Department of Insurance. However, at that time, the agent succeeded in pressuring the client into purchasing the nursing home policy. She told the local project that the agent would not leave until the client signed the check. She has an income of $1000 per month and less than $7000 in savings. The agent left no description of the policy benefits. The policy cost $684 a year and would cover the client for only two years, if she met the conditions. Upon the suggestion of the HICAP project, the client called her agent to obtain information on the policy and clarify the benefits and he became very rude to her. Consequently, the client decided to stop payment on her check and to cancel her coverage.

Most counseling programs are new. The HICAP program in California, established in 1984, is the most well-funded program and prepares an annual report that comprehensively describes its efforts. The director of the HICAP program estimates that it saves senior citizens twice the amount of its annual budget -- certainly a good example of public money well-spent. The Benefit Specialist program in Dodge County, Wisconsin, with a small paid staff and nine benefit specialist volunteers, recovered over $300,000 for the elderly in Dodge County.

The proposed legislation could help states without programs establish them and could help existing programs expand to reach more senior citizens. Consumers Union strongly supports measures, such as Senator Pryor's legislation, aimed at ending the abuses of elderly consumers in the Medigap market.

Thank you for the opportunity to appear today.



CHRISTIAN BROTHERHOOD

530 Bedford Rd. Bedford, Texas 76022 817/282-7017

Important Notice
To All Church Members

Dear Member:

We are providing information about a program of total Medicare Supplement protection.

A most significant feature is that it **pays 100% of the difference** between what a doctor charges and what Medicare pays. That is, payments are not limited to Medicare "approved" charges. This program simply pays the difference . . . **all of it!** Of course, it also pays the deductibles under Part A Medicare.

The purpose of our inquiry is to verify interest in a truly complete package of Medicare Supplement coverage at an exceptionally favorable cost.

To this end, we would appreciate your cooperation in filling out the questionnaire on the reverse side. A postage paid envelope is enclosed. Thank you for your attention.

Bob Rogers

Bob Rogers
Christian Brotherhood

Form 5100

Christian Brotherhood is not affiliated with any church or denomination.

SOCIAL SECURITY

IMPORTANT 1989 BENEFITS UPDATE

The following information is extremely important to you and your family.

If you are between the ages of 50 and 85, you may qualify for a Social Security Funeral Expense Benefit. However, this benefit is thousands of dollars below the total cost of today's funeral expense.

Return the postage paid reply card today and you will receive information on this benefit and information on a final expense program designed to pay those expenses not paid by the Social Security benefit plan.

If you are between 50 and 85 years of age, you may qualify to receive information on a final expense program that will pay up to **$10,000** to your beneficiary.

This plan was designed to prevent the excessive cost placed on your survivors.

It is very important that you know all the benefits available to you. To receive more information on this plan designed for today's seniors, return the postage paid Information Request Card today.

American Health Referral Group
Social Security Death Benefits Southwest Regional Office
Ft. Worth, TX 76161-9962

Detach this card and mail today!

Name ______________________
Add. ______________________
City/State ______________________

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
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SOCIAL SECURITY DEATH BENEFITS
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P.O. BOX 164069
FT. WORTH, TEXAS 76161-9962

MR NAN B DUETT

SPECIAL
REPORT TO
MEDICARE
MEMBERS

NAN - THIS
IS GOOD INS.

New Changes In Medicare That Affect You

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CHRISTIAN FIDELITY LIFE INSURANCE CO.
WAXAHACHIE, TEXAS 75165

The CHAIRMAN. Thank you very much, John, for your statement.

We are now going to hear from Mr. Ronald Gaiser, a former President and Chief Executive Officer of an insurance company. You are now, I understand, an attorney in the Birmingham area who works on insurance cases involving bad faith, et cetera. We look forward to your statement this morning.

STATEMENT OF RONALD O. GAISER, JR., PRIVATE ATTORNEY, BIRMINGHAM, AL

Mr. GAISER. Thank you, Senator Pryor.

You have given us a laundry list of things to talk about. I will start with marketing abuses.

The sale of Medigap insurance by use of fraud has been widespread. It includes sale of more than one Medigap policy to the same individual, unnecessary duplication of coverage, "twisting" testimonials by prominent Americans to scare our senior citizens into believing that an indispensable need exists for Medigap insurance, and reverse or post-selection underwriting.

Large numbers of agents are recruited in order to market senior citizens in each and every city, town and countryside. To do this, a company must recruit agents well beyond its ability to train and supervise. Normal supervisory ratio of approximately 6 to 1 becomes 20 or even 30 to 1.

The education of Medigap agents shows little resemblance to the typical career agent with a major insurer who normally possesses extensive education. High pressure marketing techniques find older citizens easy prey. This leads to viewing a prospect as one's pigeon or mark instead of a man or woman of worth and value.

Sale of unnecessary policies prevails. Insurance sales, when properly directed, revolve around an individual's needs. Against the backdrop of need, an insurance purchaser must weigh the costs.

In making such an assessment and applying it to Medigap insurance, it is conceivable that no one needs a Medigap policy, the reason being that Medigap policies fulfill such a small need and do so at a very high cost.

Frivolous variation between policies exist. In my opinion, companies intentionally add teaser type benefits for the purpose of inducing replacement. Each replacement generates new commissions for agents. Each replacement necessitates a new six-month waiting period for which pre-existing conditions are not covered. Thus, it benefits the company by limiting the exposure. The replacement policy is exposed to reverse and post-selection underwriting.

There is an old saying in the insurance business, "insurance is the most sold, least read, best seller." Insurance policies are written by lawyers to be understood by lawyers expert in insurance. Even in the most benign environment, the consumer will be confused as to the subject of insurance, more so with regard to the older consumer.

The insurance industry is regulated in both the legislative and judicial mode. The legislative mode has as its primary instrument of regulation the State insurance departments of the respective States.

These departments have responsibility for approval of policy forms, examination of companies, enforcement of fair trade laws, and other duties relating to day-to-day operations of the insurance industry.

The legislative mode is primarily responsible for the enforcement aspects of insurance. It possesses powerful common law tools such as punitive damages.

The dual regulation between the legislative and judicial mode has produced a very healthy industry. This is especially so in development of a high degree of public accountability. If lack of accountability was to come to the insurance field as it has to the securities field, it would only take a short time to have a substantial negative impact.

The Phillips case, this was a Medicare sale fraught with marketing abuse, agent ignorance, the sale of an unnecessary policy, and consumer confusion. The case was tried twice; it resulted in a substantial jury verdict produced, in part, due to the insurer's willful violation of the minimum benefits standards imposed by the NAIC model regulation—in Alabama Regulation 71.

In conclusion, a very selfish group of insurers has stepped forward to take advantage of our older Americans. These insurers have developed a black mark upon the integrity of the insurance industry.

I favor any measure which would limit, restrict, discourage or in any way impede an insurer from profiteering at the expense of this very vulnerable group of Americans. In my opinion counseling will greatly assist the older citizen.

A counselor can assess the need, compare the cost, compare policies, assist in filing claims, explain the incontestable period, scan the application for misrepresentations which may be used to void coverage, and discourage insurance purchases from unscrupulous agents and insurers.

A counselor, when properly trained, can steer the older buyer toward the maximization of his or her insurance buying power and away from further insurance altogether when dictated. Since profit motive will not be a factor, it is likely counseling will be of substantial assistance to the older American besieged by Medigap salesmen.

One final comment, I believe the senior citizen should have at least a 30-day period with which to look at a policy, examine it, and return it for a full refund so that the counseling program would have it's maximum possible impact.

Thank you.

[The prepared statement of Mr. Gaiser follows:]

I have been asked by Senator David Pryor to comment on several items of importance relating to the bill to establish a grant program to provide health insurance information and assistance to individuals eligible to receive benefits under Title XVIII of the Social Security Act, and for other purposes for older Americans concerning medigap insurance. The items on which my comments were requested include:

1. Marketing abuses.
2. Agent ignorance.
3. High pressure marketing techniques.
4. Sale of unnecessary policies.
5. Frivolous variation between policies.
6. Consumer confusion.
7. The limits of our legal system to address abuses.
8. "The Phillips Case."
9. Relate my experience in the insurance industry as a career agent, manager, general agent, and as a practicing attorney to the problems of medigap insurance.

MARKETING ABUSES

I have a well informed opinion that no area of insurance has more marketing abuse than the medigap area. This is viewed from a personal perspective as an agent, agency executive, and attorney. I have also been asked and have given testimony in court on the subject of marketing and other abuses in the medigap area. The sale of medigap insurance by use of fraud has been widespread. It includes:

* The sale of more than one medigap policy to the same individual;
* Causing unnecessary duplication of coverage;
* "Twisting," or the illegal replacement of an in force policy with another policy by means of incomplete or unfair comparison;
* Use of "testimonials" by prominent Americans to scare our older citizens into believing that an indispensable need exists for medigap insurance;
* The use of "reverse" or "post selection" underwriting (This is a highly unethical procedure whereby an insurance company initially makes either no review of an insurance application,

or a mere cursory review. Coverage is then issued. Then, upon submission of the first claim, the application is underwritten or reunderwritten. Upon the finding of a false representation in the application, the policy is then rescinded, and the claim is denied. This is so in spite of the fact the false representation was either fully discoverable with proper initial underwriting, or the false representation was caused by the insurance company's agent.)

AGENT IGNORANCE

"Agent ignorance" abounds in the medigap area. Medigap insurance produces extremely high profit margins for insurers, thus large numbers of agents are recruited in order to market senior citizens in each and every city, town, and countryside. To do this, a company must recruit agents well beyond its ability to train and supervise. A normal supervisory ratio of approximately six to one becomes twenty or even thirty to one. Education consists of meeting basic state licensing requirements, plus the memorization of a "canned sales talk," and little more. Training is frequently no more than joint calls on a handfull of prospects. A typical agent cannot even define such insurance terms as "indemnity," "co-insurance," and "incontestability." Neither can he nor she describe the important effect of "representations" upon the medigap insurance contract. The education of the medigap agent shows little resemblance to the typical career agent with a major insurer. Most career agents have had extensive education and training, including one or more of the following: LUTC (Life Underwriters Training Counsel); CLU (Chartered Life Underwriter, 12 courses); CPCU (Chartered Property Casualty); CFC (Chartered Financial Consultant); and a host of other formal and informal education and training programs.

HIGH PRESSURE MARKETING TECHNIQUES

Older Americans often suffer from forms of memory loss. Their vision is often impaired, and they have hearing loss. Medical expenses threaten their independence and ability to be self sustaining. These factors and other factors make older Americans particularly prone to high pressure sales and marketing techniques. Possessed with a highly developed "canned presentation," an agent finds the older prospect easy prey.

I find high pressure marketing techniques particularly offensive in that it leads to what noted psychologist Edwin O.

Timmons describes as, "viewing your prospect as your 'pigeon' or 'mark,' instead of as a 'man or woman of worth and value.'" I strongly recommend a thirty day inspection period be given a medigap purchaser for which he or she can return a policy for full refund. This will not eliminate high pressure marketing abuse, but it will give time for a review, and should this bill be approved, it will provide time for counseling to be completed.

SALE OF UNNECESSARY POLICIES

Insurance sales, when properly directed, revolve around an individual's "needs." The young family has a "need" to protect family income, hence the need for life insurance and disability income protection. All Americans have a "need" for quality health insurance, homeowners insurance, and automobile insurance. Insurance is very expensive, so against the backdrop of "need" an insurance purchaser must weigh the "cost." In making such an assessment, and applying it to medigap insurance, it is conceivable that no one needs a medigap policy. The reason being that medigap policies fulfill such a small need, and do so at a very high cost. Perhaps no where would the proposed counseling bill be of more benefit to the older insurance buyer than in this area. A counselor, when properly trained, can assess an individual's "need cost" ratio, and steer the older buyer toward the maximization of his or her insurance buying power, and or away from further insurance altogether. Since profit motive will not be a factor, it is likely counseling will be of substantial assistance to the older American besieged by medigap salespersons.

FRIVOLOUS VARIATION BETWEEN POLICIES

The National Association of Insurance Commissioners Model Regulation (Regulation 71 in Alabama) makes an attempt to eliminate frivolous variation between policies. Nevertheless, unscrupulous insurers frequently have several policies which contain minor differences in benefits. This permits an agent to make policy comparisons for the purpose of inducing replacement. I have met with individuals who owned several different medigap policies in a period of only a few years. Inquiry reveals that the individual was led to believe that each new policy was superior to the old policy. My analysis of the various policies revealed that there was no significant difference in any of the policies. It is my opinion companies intentionally add a "teaser" type benefit for the purpose of inducing replacement. Incidentally, the replacement very often involves policies of the very same insurer and not just a competitive insurers' policy. Each replacement generates new commissions for agents, thus the incentive to replace. Each replacement necessitates a new six month waiting period for which preexisting conditions are not covered, thus it benefits the company by limiting the exposure. The replacement policy is fully exposed to the "reverse" or "post selection" underwriting previously noted via a new incontestible clause beginning with the new policy's date of issue.

CONSUMER CONFUSION

There is an old saying in the insurance business, "Insurance is the most sold, least read, best seller!" It is anywhere from difficult to impossible to decipher insurance terms by a layperson -- even many experts have difficulty. Insurance policies are written by lawyers to be understood by lawyers expert in insurance. Interpretation of an insurance policy requires knowledge of insurance underwriting, claims ratios, actuarial concepts, present value calculations, and claims practices. These are both insurance and legal concepts. Even in the most benign environment, the consumer will be confused as to the subject of the insurance. More so with regard to the older consumer. I am of the opinion that counseling will greatly assist the older citizen. A counselor can: assess the need; compare the cost; compare policies; assist in filing claims; explain the incontestible period, scan the application for misrepresentations which may void coverage; and discourage insurance purchases from unscrupulous agents and insurers.

THE LIMITS OF OUR LEGAL SYSTEM TO ADDRESS ABUSES

The insurance industry is regulated in both the legislative mode and the judicial mode. The legislative mode has as its primary instrument of regulation the state insurance departments of the respective states. These departments have responsibility for: licensing (both companies and agents); approval of policy forms, including assessment of reserves and loss ratios; examination of companies; enforcement of "fair trade" laws; and the more or less day-to-day operations of a very vast and substantial business. The legislative mode is primarily responsible for the enforcement aspects of insurance. It possesses powerful common law tools to deal with offending companies and agents. By meting out punitive damages, a strong degree of accountability has developed which has been very healthy in that it encourages companies to hire quality agents, train them, supervise them, and discipline them. It also encourages companies to settle disputes quickly and equitably. The judicial mode also has responsibility for contract interpretation, assessment of insurable interests, subrogation, coordination of benefits, interpleaders, the doctrines of reasonable expectation and the warranty of fitness, and many other areas not suited to legislative regulation.

I believe that the dual regulation between the legislative and judicial mode has produced a very healthy industry. It has been instrumental in the growth and development of a strong private insurance system by not being overly restrictive, and thus stifling growth. The bill being considered by your committee is a good example of how the federal government can assist in the improvement of aspects of an existing industry without being overly invasive.

I can think of no reason to alter the dual method of regulation that exists in the insurance field. In fact, one would only have to look at the securities business to see how effective the insurance business is presently being regulated. If the lack of accountability were to come to the insurance field as it has to the securities field, it would take only a short time to have substantial negative impact.

"THE PHILLIPS CASE"

The Phillips case is a case that went to trial twice here in the State of Alabama. It involved nearly all of the elements your committee is addressing. The sale was fraught with marketing abuse, agent ignorance, the sale of an unnecessary policy, and consumer confusion. The case was tried twice. It resulted in a substantial jury verdict. The verdict was upheld through post trial motions, and a settlement was reached without appeal to the Alabama Supreme Court. As an element of damages, Mrs. Phillips' attorney, R. Ben Hogan of Birmingham, produced evidence which noted that the insurer had violated Alabama Insurance Regulation 71 (the NAIC Model Regulation previously noted) as to minimum benefit standards whereby at least 60 percent of the aggregate amount of premium collected in the case of individual policies must be returned to policyholders in the form of aggregate benefits. The overcharges formed the basis of the punitive damages.

I have enclosed copies of the sales proposals which were used to deceive Mrs. Phillips (enclosure 1 and 2). I have also enclosed a copy of the policy provision to which the description of full coverage relates (enclosure 3). The combination of agent ignorance (The agent was taught to believe the policy paid everything that Medicare did not pay, and represented the policy accordingly.); the double talk contained in the description of coverage (A high school English teacher dissected the sentence to read, "X pays all."); and Mrs. Phillips' gullibility made this a classic fraud case. The case shows the value of punitive damages to punish an entity who willfully violates established common laws and insurance statutes, and provides a deterrent to future violations by agents and insurers.

RELATE MY EXPERIENCE IN THE INSURANCE INDUSTRY AS A CAREER AGENT, MANAGER, GENERAL AGENT, AND AS A PRACTICING ATTORNEY TO THE PROBLEMS OF MEDIGAP INSURANCE

Besides the comments that I have previously made, I would like to add the following as pertaining to Senator Pryor's request. This being, the insurance industry is a vital industry, and a great industry consisting of American men and women of the very highest calling, a calling of commitment of service to others. If I were a Senator, I would be very reluctant to make any significant changes to this great industry other than of the type a bill like the one being considered would make. I endorse this bill because it is non-invasive. It is centered around voluntary citizen participation in counseling the elderly. It fills a very definite need which is not adverse to the overall interests each of us have in a strong insurance industry. It does not distort the accountability which is vital to the integrity of the insurance business.

The older American has very special needs. Among them is the need for quality health insurance that permits them to enjoy the balance of their lives without the threat of financial ruin. Upon this basis, Medicare was established. A very selfish group of insurers stepped forward to take advantage of our older Americans. In doing so, these insurers have delivered a black mark upon the integrity of the insurance industry. I favor any measure which would limit, restrict, discourage, or in any way impede any insurer from profiteering at the expense of this very vulnerable group of Americans. This includes, in addition to the adoption of the bill being discussed, the following:

- Institute a 30 day inspection period (as noted previously);
- Substantially restrict the amount of retention an insurer may retain, and increase the amount that must be returned to the insured (60% is not enough);
- Do not substantially disturb the present methods whereby insurance is being regulated, particularly in the aspect of punitive damages for fraudulent and malicious offenders of the existing rules and regulations that govern the sale of medigap policies;
- Require that medigap policies be written in simple and understandable language;
- Permit only one standard medigap policy to be marketed (There is only one Medicare, why should there be many different medigap policies?);
- Require that persons giving testimonials be licensed in the states where the testimonials are aired or assimilated.

Thank you for the opportunity to address your committee. Best wishes to each of you as you tackle this sensitive problem.

The **Chairman**. Thank you, Mr. Gaiser. We appreciate your testimony this morning. We will have some questions in a moment.

Mr. Ron Taylor, Insurance Commissioner from the State of Arkansas who is representing the National Association of Insurance Commissioners. Ron, we appreciate you being here this morning.

STATEMENT OF RON TAYLOR, INSURANCE COMMISSIONER, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, ACCOMPANIED BY CAROLE OLSON, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. **Taylor**. Thank you, Mr. Chairman. It is indeed an honor to be here.

The **Chairman**. By the way, the reason I am not using the lights anymore, they were about to blow out the whole building's electrical apparatus for some reason. I don't understand all that, so if you could keep your statement roughly in the 5 minute period, we will have some questions.

Mr. **Taylor**. I will be mindful that they are on, sir.

We appreciate your providing the National Association of Insurance Commissioners with the opportunity to comment on this proposal. The NAIC, if you do not know, is composed of the insurance regulatory officials from the 50 States, Puerto Rico, the Virgin Islands and American Samoa, Guam and the District of Columbia.

We applaud your interest in providing assistance to the States for the development of grant programs to create counseling programs for the elderly. We do think that the NAIC and its members should be designated to receive the grants through an uncomplicated application process.

Insurance commissioners have the knowledge, the vital interest and the experience to properly set up and administer those programs. We have, in the past, had experiences with Federal agencies where we have lost valuable products.

This particular "Guide to Health Insurance for People with Medicare," is an example of that. It is a guide we developed in conjunction with the Health Care Financing Administration. The Health Care Financing Administration notified us in January that they could not fund this product for this year.

The NAIC, within two weeks, took it upon itself to work into the budget to publish this guide and disseminate 500 copies to each State.

We do feel that we have a cooperative spirit in working with Federal agencies. This is a very good example of that. We have produced this guide since the early 1980s, I'd say the last 8 or 9 years.

The NAIC and its members react very timely to the concerns of consumers. When the action on catastrophic was uncertain, the NAIC developed a transition regulation to be implemented immediately upon decision on that legislation.

That transition regulation basically provided that there be no duplicated coverages or excess charges, or any other abuses in the policies that were in the marketplace as a result of the repeal of the Catastrophic Act.

Within 8 days of the signature of that particular repeal, I had this regulation in place in Arkansas and most of my counterparts had it in place within 2 or 3 weeks.

The NAIC has a prior commitment to consumer concerns. I mentioned the guide to people with Medicare. We have also done a health insurance shoppers guide. In June of this year, we hope to have a video tape outlining Medicare changes as a result of the catastrophic repeal.

We have done specific regulations dealing with the advertisement of outstanding health insurance in general and specifically regarding Medicare. The Medicare advertising regulation does provide, as has been mentioned here, for an abuse with cold or lead advertising.

If it solicits an invitation to come and make a presentation, that must be filed with insurance departments and it is considered advertising and it must be conspicuously displayed on that mailout material.

NAIC has adopted a resolution encouraging States to do counseling programs very similar to this. States with formal programs include North Carolina, California, Kansas, Wisconsin, New Jersey and others.

Most other States, including Arkansas, Florida, and North Dakota have less formal programs, but we do attempt to do that within our budget constraints.

Many of the problems that have been mentioned are addressed by a set of amendments that we call the Consumer Protection Amendments which were adopted in December by the NAIC.

They require guaranteed renewability of products. They require continuation or conversion if you are in a group product situation. They limit commissions to agents, and in particular, they require that commissions in the second and subsequent years for a reasonable number of years be limited to 50 percent of the first year commission. This eliminates the problem of churning.

In addition to that, if a policy is replaced and the coverage is similar, the commission that the replacing company can pay the agent is limited to their renewal commission rate and not their new policy commission rate.

We have expanded the outline of coverage to simplify the comparison of these benefits because there are a myriad of products out there. We think we have provided for consumers to adequately compare what they have and what they would be purchasing.

We have imposed additional duties on companies and agents alike, and we have required—someone mentioned preexisting conditions—that there be no new preexisting conditions on those policies.

One more point, Mr. Chairman. There is a 30-day free look provision and policyholders do now get a 30-day free look and may return that policy within that time period for a full refund.

In summary, we support very strongly this proposal that you have. We do feel that the National Association of Insurance Commissioners would provide a perfect forum to take care of the National Data Collection Center.

We have a database now with some consumer information in it and it would be a perfect place to do that. We feel the States should be allowed to apply for these grants to State insurance departments.

We do understand there will be reporting requirements and we could comply with whatever requirements HHS imposed upon us. We would certainly offer our assistance in helping with this program or any others to assist our senior citizens.

If you have questions, I would be glad to entertain them or I have Ms. Carole Olson from our NAIC central staff that can help us with those.

[The prepared statement of Mr. Taylor follows:]

TESTIMONY
OF THE
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
ON
THE HEALTH INSURANCE COUNSELING AND ASSISTANCE ACT OF 1990

Before The

SPECIAL COMMITTEE ON AGING
U.S. SENATE

March 7, 1990

Ron Taylor
Arkansas Commissioner of Insurance

INTRODUCTION

Thank you for providing the National Association of Insurance Commissioners an opportunity to comment on the proposed "Health Insurance Counseling and Assistance Act of 1990." The NAIC represents its members who are the fifty insurance officials of each state, the District of Columbia, Guam, American Samoa, Puerto Rico and the Virgin Islands. We applaud your interest in providing assistance to the states for the development of seniors' counseling programs and therefore support the concept of developing a grant program for states.

THE HEALTH INSURANCE COUNSELING AND ASSISTANCE ACT OF 1990

With respect to your bill, the NAIC supports the concept of furnishing funds to state insurance departments who desire financial assistance to establish counseling programs. We recommend that a State insurance department be designated as the entity which would apply for the funding because of its vital interest and knowledge of the information which is to be disseminated. We also support an uncomplicated application process to facilitate and encourage states to participate in the voluntary program.

We understand that reporting requirements would be necessary for recordkeeping and enforcement purposes and that a federal agency would be the appropriate mechanism for this activity, but we suggest that the establishment of a clearinghouse for information be delegated to the NAIC. We believe that the NAIC could perform the functions identified in the bill in an efficient manner. However, our experience with funding of this kind of activity at the federal level, especially in the Medicare supplement area, is that budget cuts may occur which can diminish the effectiveness of a program.

A severe budget cut prevented the Health Care Financing Administration this year from distributing the Guide to Health Insurance for People with Medicare to the state insurance departments and others. The NAIC and HCFA have jointly produced this Guide since the early 1980s. Although the Health Care Financing Administration has performed this distribution service for the last several years, and is obligated under federal law to make the Guide available, we were informed in mid-January that the funds would not be available for distribution of the 1990 Guide. Because of the importance of this information to the consumer, the NAIC, of course, made special arrangement to make 500 copies available to each state insurance department and accomplished this within two weeks of notification by the federal government. We are therefore hesitant to rely on federal funds as the sole mechanism for providing the kind of services you suggest.

The NAIC has also demonstrated that it would respond quickly once legislation is enacted. As you know, the NAIC developed the Medicare Supplement Transition Rule and permanent revisions to the NAIC Medicare supplement model act and regulation well before the deadline established in the Catastrophic repeal legislation. For these reasons, the NAIC believes it would be entirely appropriate for us to serve as a national clearinghouse. We have worked cooperatively with federal agencies within the Department of Health and Human Services and express our willingness to continue to do so.

We would be more than happy to review these and other technical drafting issues in more detail at your convenience.

NAIC POSITION ON COUNSELING PROGRAMS

The NAIC has long promoted the development of educational materials for use by consumers as they shop for health insurance. Over the years, the NAIC has prepared several publications for use by the states including the Health Insurance Shoppers Guide, the Health Insurance Shoppers Guide for Senior Citizens, the Guide to Health Insurance for People With Medicare and the Cancer Information Sheet. In addition to these prototypes, the NAIC recommends a number of consumer disclosures and advertising requirements which assist purchasers of health insurance. An example is the NAIC Rules Governing Advertisements of Accident and Sickness Insurance which specify the content of health insurance advertisements and place limitations on certain deceptive practices. By June of 1990 we will complete a Shoppers Guide for Long-Term Care Insurance and furnish it to all state insurance departments. This guide will serve as a useful document in any senior education program.

In December of 1989, the NAIC adopted "Consumer Protection Amendments" to the NAIC Medicare Supplement Insurance Model Act and Regulation, designed to assist purchasers of insurance to supplement Medicare, which:

1. Require guaranteed renewability of individual policies and require continuation or conversion of group coverage;

2. Place a limit on the differential between first and second year agent commissions (first-year commissions can be twice as much as second year); second and subsequent years' commissions must be the same amount and must be paid for a reasonable number of years;

3. Require a new arrangement in the outline of coverage to facilitate comparison shopping;
4. Require additional responsibilities of agent and company during application process;

5. Require companies to establish auditable marketing procedures to verify compliance with the revisions;

6. Prohibit the sale of more than one Medicare supplement policy except under certain circumstances;

7. Require companies to report multiple policies; and

8. Prohibit new pre-existing conditions in any replacement policy.

All of the above measures will enhance the protections afforded to the consumer. Some of these consumer protection amendments are regulatory tools, but most of them (1, 3, 4, 6, 8) can be communicated directly to the consumer through the outline of coverage and the application process. And a counseling program for seniors provides a perfect opportunity to disseminate this type of information.

In conjunction with the consumer protection amendments, the NAIC adopted a resolution stressing the significance and encouraging the development of counseling programs (copy attached). The states of California, Idaho, Illinois, Kansas, Maryland, Mississippi, Montana, Massachusetts, Michigan, New Jersey, North Carolina, Oregon, Tennessee, Texas, Washington and Wisconsin have implemented formal seniors' counseling programs. Attached are brochures describing the Washington Senior Health Insurance Benefits Advisors (SHIBA) program and the North Carolina Seniors Health Insurance Information Program (SHIIP). Many other states, for example Arizona, Florida, Vermont, North Dakota, the District of Columbia and Arkansas, conduct counseling activities on a more informal basis.

As you are already aware, states have noted that lack of funding hampers their ability to extend senior counseling services to consumers. A recent study conducted by the American Association of Retired Persons (AARP), in conjunction with the NAIC, revealed that many of the less populated states lack the necessary funds and staff to institute a formal program along the lines in your bill. On the other hand, many of the states are presently disseminating consumer education information, but on a less formal basis as mentioned above. For example, state insurance departments develop press releases and other public information pieces and disseminate information through senior citizen gatherings. Toll-free hot lines are another information-sharing device which are in place in 23 states. These efforts and the educational efforts of consumer services divisions within the departments often go unnoticed, although they are a valuable tool for distributing important information to the elderly about health insurance.

SUMMARY

The NAIC supports the concept of establishing a voluntary grant program for seniors' counseling programs. States have experienced limited success in obtaining funds to institute programs of this nature. The availability of funds would hopefully prompt states to participate in the grant program. The NAIC offers its assistance in serving as a clearinghouse of information on health insurance, including information which we currently collect and maintain on the existing counseling programs.

If there are any questions, I would be more than happy to answer them.

RESOLUTION

ENCOURAGING DEVELOPMENT OF COUNSELING PROGRAMS

WHEREAS, the NAIC Medicare Supplement and Other Limited Benefit Plans Task Force has identified several consumer protection measures in the Medicare supplement area and has recommended amendments to the NAIC Medicare Supplement Insurance Minimum Standards Model Act and Regulation,

WHEREAS, in addition to these amendments, the Task Force believes an effective consumer protection measure is the development of counseling programs for senior citizens,

WHEREAS, senior health insurance counseling programs established in various states* have assisted in the education of the elderly about the benefits, costs and other aspects of Medicare supplement and other health insurance coverage,

THEREFORE, the NAIC encourages the states to develop and implement counseling programs, and to appropriate funding where necessary, to assist in educating the elderly about the cost, benefits and other aspects of Medicare supplement and other health insurance.

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* California, Idaho, Illinois, Kansas, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Jersey, North Carolina, Oregon, Tennessee, Washington and Wisconsin.

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S.H.I.I.P.

N.C. DEPARTMENT OF INSURANCE

SENIORS HEALTH INSURANCE INFORMATION PROGRAM

JIM LONG
NORTH CAROLINA INSURANCE COMMISSIONER

WHY A S.H.I.I.P. PROGRAM IS NEEDED . . .

The position of the person over 65 is unique in the medical insurance market. While Medicare provides basic medical coverage for most senior citizens, it leaves gaps in protection that can be filled by the private insurance sector and/or by Medicaid.

In North Carolina, approximately 730,000 persons are eligible for Medicare supplement policies. Nearly 40 insurance companies offer these Medicare supplements. Many seniors seek assistance in determining the types and amounts of coverage they need, and how to apply for their medical benefits.

Common questions among seniors include: "How much medical coverage is necessary for me?" and "Should I change or replace my current medical insurance policy?"

The S.H.I.I.P. program trains volunteers to answer these questions and many more. It aims to make medical coverage information readily available to senior citizens in North Carolina.

Many senior citizens are unsure about "Medigap" insurance and the rules and regulations surrounding the sale of these policies. With S.H.I.I.P. volunteers at their retirement homes or senior centers, senior citizens will now have someone to turn to for answers.

Senior citizens who are armed with facts and someone to turn to when they have questions are less likely to become victims of unscrupulous sales schemes. With a S.H.I.I.P. volunteer to help them review policies and to answer questions about the kinds of things to look for, senior citizens will become more and more aware of their rights and the agent's responsibilities in an insurance transaction.

WHAT IS S.H.I.I.P.?

Many senior citizens have questions about medical protection, but don't know where to find the answers. S.H.I.I.P. (Seniors Health Insurance Information Program) trains senior citizens and other volunteers in the complete spectrum of medical protection available to persons age 65 and over.

The S.H.I.I.P. training program includes classes focused on medical insurance, consumer protection and related subjects.

Having completed the S.H.I.I.P. program, volunteers may serve as active "counselors" for other seniors in their communities. These volunteers are prepared to answer basic health insurance questions and provide effective counseling to citizens who are unaware of the gaps in coverage provided by Medicare.

WHO IS INVOLVED IN S.H.I.I.P.?

Commissioner Long's staff is responsible for S.H.I.I.P. training. The staff sees to it that information about Medicare supplement insurance, and the laws and requirements surrounding its sale, is provided during the training sessions. Information about community legal services, and private insurance is also included in the sessions.

Though the S.H.I.I.P. program is open to all interested persons, social agencies, and senior organizations, it primarily seeks to train senior citizens to advise other senior citizens of their medical benefits and rights.

To The Senior Citizens of North Carolina:

Your North Carolina Department of Insurance has developed this booklet to tell you about our Seniors Health Insurance Information Program - SHIIP.

Many times senior citizens find that the offerings of State, Federal, and private health insurance programs can be quite confusing and difficult to work with. At the Department of Insurance we see people who are not sure how much more supplemental health insurance they really need, or we meet with people who do not understand their insurance policies. The SHIIP program is an effort to solve these problems.

It is important, I think, to note that SHIIP is a volunteer program. The efforts of this program are coordinated with local citizens organizations which means that there is little cost to the State.

We in the Department of Insurance are very concerned about all aspects of insurance but I am aware of the unique problems facing the senior citizens of North Carolina...particularly those of you living on a fixed income. The average family in North Carolina spends about 10% of its income on insurance and it is important that you get the best protection possible for every dollar you spend. Hopefully, the program described in this booklet will give you a better understanding of your supplemental health insurance and answer the questions you may have about what and how much insurance you need.

Sincerely,

Jim Long

Jim Long
Commisisoner of Insurance

S.H.I.I.P.

(Seniors Health Insurance Information Program)

A NON PROFIT RETIRED VOLUNTEER ORGANIZATION TO HELP LOCAL SENIOR CITIZENS WITH HEALTH INSURANCE.

S.H.I.I.P. VOLUNTEERS ARE SPECIALLY TRAINED BY THE OFFICE OF THE NORTH CAROLINA INSURANCE COMMISSIONER TO HELP RETIRED PERSONS WITH THEIR HEALTH INSURANCE PROBLEMS.

THERE IS ABSOLUTELY NO SELLING OR SOLICITING OF INSURANCE.

FOR HELP OR INFORMATION WITH MEDICARE OR MEDICARE SUPPLEMENT INSURANCE CALL 832-9080 MONDAY THRU FRIDAY 9:00 A.M. TO 4:00 P.M.

DEPARTMENT OF INSURANCE

1,000 copies of this public document were printed at the cost of $118.31.

An Introduction to SHIBA

(Senior Health Insurance Benefits Advisors)

From the Office of
Dick Marquardt, Insurance Commissioner

Published: July 1989

SHIBA is a creative blend of professional staff and community volunteers working to:

1. **Educate** qualified senior volunteers to counsel other seniors on the senior health insurance policies now being marketed by the insurance industry;
2. **Inform** seniors of their rights and opportunities in the area of health insurance;
3. **Serve** as an effective sounding board for senior health care insurance consumers.

You'll want to read the rest of this brochure if . . .

☐ ***You are*** a senior citizen with a strong desire to help others understand their insurance options or their general insurance problems;

☐ ***You are*** a senior citizen or the guardian of a senior citizen and you have questions about the hundreds of insurance products aimed at your pocketbook every day;

☐ ***You are*** a seniors agency administrator concerned about protecting your clientele.

Why SHIBA?

Insurance is a complex business. Few persons outside the industry have the opportunity, the time or disposition to master it. For many of us, insurance isn't something we spend a great deal of time studying. We want to buy the type and quantity of insurance the law and our common sense tell us we need to protect ourselves, our family and property.

But as we grow older, we begin to spend more time thinking about insurance and how it can help us with escalating health care expenses. We now begin to appreciate how difficult it can be to make intelligent, well-informed choices about insurance. We need accurate information in a form that we can understand in order to make good decisions about insurance.

In 1979, SHIBA was created specifically to address this need. SHIBA helps us navigate the maze of state, federal and private, (including fraternal or association-sponsored) insurance options confronting seniors in Washington state.

The mission of SHIBA is to educate and counsel senior citizens about Medicare, Medicare supplement and long-term care health insurance available to them in Washington state.

No other department of government at any level has the trained personnel to counsel retired persons about their insurance options.

With its statewide network of more than 450 carefully trained volunteers, SHIBA helps us make better choices about health and long-term care insurance. That's why SHIBA.

How SHIBA works

Most of the credit for SHIBA's success rests with its core of committed volunteers from the ranks of senior citizens throughout the state. They're the people who tackle the intricacies of insurance policy analysis and federal Medicare programs and learn how to explain them to us. These volunteers are recruited from the general population with the help of senior citizen organizations throughout the state.

The Commissioner: The Insurance Commissioner recognized the need for better health insurance information among senior citizens and directed that SHIBA be developed to meet that need. He made available the resources of his office to start and maintain the service.

The Regional Representatives:

Two regional program representatives are frequently on the road, training volunteers in small and large communities in the intricacies of Medicare supplement and long-term care insurance. Each representative is assigned a territory and is responsible for training the SHIBA volunteers in that territory. These representatives also serve as liaisons to the sponsoring agencies and nonprofit organizations which sponsor the SHIBA volunteer units. The representatives also participate in forums and seminars on community-based health issues.

Sponsoring Agencies: These agencies, most often nonprofit senior organizations, are SHIBA's essential link to senior citizens. They often supply office space and telephone service for SHIBA programs. Without these organizations, SHIBA simply couldn't function. Sponsoring agencies get involved to varying degrees in the actual operations of the SHIBA units; but all of them, at minimum, offer the SHIBA units a permanent location with storage for SHIBA public information and reference materials and a staffed telephone referral service. Sponsoring agencies also plan occasional Senior Insurance Forums which are used to raise senior citizen awareness of insurance issues and to recruit SHIBA volunteer counselors.

Volunteer Advisors: These volunteers really are what SHIBA is all about. The volunteers receive more than 10 hours of technical training in Medicare supplement and long-term care insurance and how to counsel other seniors about the pros and cons of various policies in these areas.

There are more than 450 of these dedicated individuals in communities throughout the state. They answer questions from seniors who call them or who are referred by a sponsoring agency or one of the Insurance Commissioner's branch offices.

These volunteers also serve as the Insurance Commissioner's eyes and ears for the Medicare supplement and long-term care insurance policies now being marketed to seniors and for the sales and marketing techniques being used. This information is extremely valuable in helping the Insurance Commissioner monitor agent and company activities.

Volunteer Subject Experts: These are skilled members of the insurance industry who volunteer time and expertise on occasion, when SHIBA program representatives need them to explain particularly complex subjects. The Insurance Commissioner's Office makes it clear to these experts that they are not to use these educational contacts to develop sales. In other words, the persons who volunteer this time are motivated by a belief that insurance consumers should be well-educated about their choices.

Support from the Insurance Commissioner's Office:

As an enthusiastic supporter of SHIBA, Insurance Commissioner Dick Marquardt is determined that the SHIBA program receive the logistic and technical support it needs to offer quality health insurance counseling services to the state's senior citizens.

Brochures about consumer rights and all types of insurance coverage of possible interest to senior citizens are distributed in bulk to the SHIBA units on a regular basis.

The Insurance Commissioner's office also distributes, as needed, bulletins outlining how to deal with emergency situations that may affect the availability of some insurance policies or the continued operations of some insurance carriers operating in Washington state.

The point of all these support services is to make SHIBA an effective force for consumer education about health insurance for the state's senior citizens.

SHIBA and the Insurance Commissioner's Office

SHIBA is a public service of the Washington State Insurance Commissioner's Office. It is part of the Consumer Protection Division of the Office.

This makes SHIBA part of the largest consumer protection effort in Washington state government. That's right! The Washington State Insurance Commissioner's Office touches the lives of more consumers than any other agency of state government!

Although SHIBA's services are unique, they are an important part of this larger consumer protection effort. SHIBA is a part of the Consumer Protection Division because an informed insurance consumer is his or her own best protection.

SHIBA's services often generate information that supports several functions of the Insurance Commissioner's Office. For instance, SHIBA's strong training program gives the agency hundreds of sharp eyes and ears in the insurance marketplace. And this often results in valuable consumer feedback on issues or abuses of concern to the Licensing, Investigative, or Rates and Forms divisions of the Insurance Commissioner's Office.

About the Insurance Commissioner's Office

SHIBA: Regional program representatives train and supervise more than 33 local units of health care insurance counselors throughout the state as part of the Commissioner's commitment to consumer protection.

Consumer Protection: This is SHIBA's parent division. Also included in Consumer Protection is the Investigations & Enforcement division. This division follows up on written complaints against agents or companies operating or attempting to operate in the state of Washington.

Company Supervision: This unit monitors the activities of insurance companies to ensure they are operating in accordance with the laws of the state of Washington as they relate to insurance companies.

Rates & Forms: This unit reviews the hundreds of insurance policies that more than 150 companies licensed to operate in the state of Washington are marketing to the public. This unit's job is to ensure that these policies conform to the laws of the state of Washington for insurance contract and rate setting procedures.

Licensing: This unit sets standards for agent competence, supervises testing contractors and issues licenses to agent candidates who have successfully completed testing and other licensing requirements.

Continuing Education: This unit helps licensed agents update their professional skills as insurance products and the industry change. They do this by reviewing and, where justified, certifying qualified training experiences for continuing education credits. All licensed agents are required to earn a minimum number of continuing education credits on a regular basis in order to remain licensed to operate in the state of Washington.

How you can benefit from SHIBA

Senior citizens may contact SHIBA volunteers in any of several ways, each unique to the SHIBA unit's service area. Some units meet at a regularly scheduled time and place each month and counsel seniors on a first-come, first-served basis. This arrangement relies on good local publicity and an effective seniors "grapevine" of personal contacts.

Counselors in other units may respond to telephoned requests for help forwarded to them from the sponsoring agency telephone operator or from other agencies. Some of these counselors may counsel seniors over the telephone, while others will make appointments for face-to-face meetings.

Counselors who meet clients face-to-face, usually at a spot arranged by the sponsoring agency, can expect to spend 45 minutes to an hour with each client and can count on follow-up technical support from the Insurance Commissioner's office for complicated situations which go beyond the counselors' levels of expertise .

Training and counseling is serious business and demands a lot of the time and attention of the volunteers. But regional SHIBA program representatives also encourage the units to see this as a great opportunity to meet socially with other active and energetic seniors.

The mental demands of SHIBA counseling challenge some of the best minds in the senior community. Sharing time with them is always a rewarding experience.

How YOU can be a part of SHIBA

Helping senior citizens make critical decisions about protecting themselves from economic calamity in the face of rising health care costs is a heavy responsibility that the Insurance Commissioner's office takes very seriously.

That's why SHIBA volunteers undergo extensive training, conducted by experienced professionals from the Washington State Insurance Commissioner's Office.

It's also the reason the Insurance Commissioner's office attempts to maintain good working relationships with the many agencies that serve senior citizens in Washington state. These agencies provide the structure upon which SHIBA units are built.

If you have a desire to help others understand their Medicare supplement and long-term care insurance options and you are willing to commit to monthly training meetings, the SHIBA regional program representatives want you.

There are many ways you can help. You can volunteer to train as a counselor; you can provide administrative support for the SHIBA unit in your area or you can train to promote SHIBA by speaking to community groups about the program.

To find out more, contact the Washington State Insurance Commissioner's Office toll-free at ***1-800-562-6900*** and ask for the telephone number of the SHIBA unit coordinator in your community.

Senator **Graham**. Senator Pryor, is it your intention to continue?

The **Chairman**. I think I am going to continue. I don't believe that I am going to attend this joint session today, so if you are attending, go ahead and ask questions.

Senator **Graham**. Thank you, Senator.

I would like to ask Mr. Taylor a question. Several States prepare annual analyses of Medigap policies that are sold commonly within that State so that consumers can evaluate the relative coverage and cost of the alternatives in the marketplace.

How many States are doing that, and how effective do you believe that has been as a matter of consumer information and protection?

Mr. **Taylor**. Senator, I can't answer your question specifically. We think that several States do. We don't have that information.

As I mentioned, we have simplified the comparison form and it does provide for the pricing of the product so when your insured is being shown a new product, they can compare that with the one they have and compare the price against the benefits and see which is most preferable for them.

Senator **Graham**. There are a number of Medigap policies which are sold prior to retirement. Some policies are sold to individuals, some of them are sold to firms which incorporate them into a retirement fringe benefit package.

Are any of you familiar with those types of policies, and are there many abuses in this area?

Mr. **Gaiser**. I can answer that, if you like.

You are now getting into my pet area, I'd say, ERISA. The problem with ERISA is that there is no accountability. You Federal people have completely preempted the field of insurance in ERISA and there is no opportunity for any common law damages.

When a person obtains a Medicare supplement policy from an employer when an employer is sponsoring it, then he is going to be covered under the Employee Retirement Security Act of 1974. If there is any fraud, bad faith or anything of that nature, there is not going to be a remedy other than under ERISA.

You have two remedies in ERISA. One, if an individual is not given a summary plan description, they can be fined $100 a day. The other one is if they are not given a COBRA benefit, they can be fined $100 a day. Other than that, there is almost no remedy.

Where the policies are sold by employer-sponsored entities, the problem becomes even more pervasive.

Senator **Graham**. Any other comments on that question of preretirement Medigap policies?

Mr. **Taylor**. We don't specifically know of abuses. I would be glad to see that our association addresses those if Mr. Gaiser would share those with us. We are not totally preempted by the ERISA statute with regard to all products. There are some things that you have left to the States, just to clarify that issue.

Senator **Graham**. Mr. Chairman, one final question.

There was a lot of concern at the time that the catastrophic health care was being repealed that there would be massive increases in the cost of Medigap insurance. What has occurred in the months since the repeal of catastrophic in terms of the cost of Medigap insurance?

If there has been an increase in cost, is it an increase which is appropriate to the coverage now being provided in light of the repeal of catastrophic or, as some had suggested, was it a case of taking advantage of the repeal of catastrophic to have an inappropriate level of increase?

Mr. **Hildreth**. If I might respond, the first thing to point out is that one of the promises of catastrophic was that the cost of Medigap coverage would come down and those policies really did not drop as indicated or promised that they would.

There has been a subsequent increase with the repeal of catastrophic and so we are left with the situation of people paying far too much for policies and not getting a good value. One of the best indicators of that is the loss ratio standards which have not been met around the country that were established by the Baucus Amendment in 1980 in which substantial numbers of policies failed to achieve the loss ratios which are the best measurement of a good value of a policy.

Mr. **Gaiser**. I'd like to comment too, Senator Graham.

He has hit the nail right on the head on this loss ratio. We have a real problem with this 60/40 and then where they don't even meet the 60/40, many of the insurance companies—one, in particular, the Phillips case, for example—the punitive damages were based upon the insurance company's approximate 3-year period where—they didn't meet them in any of the years but the judge would only go back 3 years to adjust for the fact that they had kept even more than the 60/40.

In some of our States, like Alabama, for example, we have a very strong health care system like Blue Cross provides. Blue Cross generally operates on less than 10 percent retention. They give, in essence, 90 percent of the money back to the insured.

When Blue Cross sells Medicare supplement insurance, they are able to keep 40 percent of the premium, so they are actually developing a great deal of reserves. They can't even hide the reserves, they are developing them so fast.

That is much too high. I think for the senior people 80/20 percent might be a fair ratio, something much, much higher than 60/40, in my opinion.

Mr. **Taylor**. If I might comment on the increase in rates as a result of catastrophic, at least the NAIC never promised that the rates would go down. Utilization and medical care costs have increased and continue to increase at a greater rate than inflation in general.

Because of that, the rates did go up for most companies last year. They didn't go up as much as they would have had you not passed that Act. This year, we have seen specific to Arkansas increases of 11 to 40 percent.

The lost ratio question, 95 percent of the premium volume in the GAO report was from companies that met those loss ratio standards. I'm not defending the 5 percent that did not meet those standards, but the problem is not of such a magnitude that there are mass numbers of people being abused by those rates.

We do have new loss ratio standards and a program for that. Ms. Olson could explain that if you would like for her to.

The **Chairman**. Yes, if you would.

Ms. **Olson**. Mr. Chairman, this year the NAIC is considering a substantial set of loss ratio guidelines which have been prepared by members of the Medicare Supplement Task Force. These guidelines which have not yet been adopted are targeted for adoption in June.

What does guidelines do is explain to the State insurance department, actuaries and others, how to monitor loss ratio information which is submitted to them by the insurance companies. In addition, the guidelines also explain the information that comes to the States from the NAIC.

In addition to the guidelines, the NAIC expects to consider revisions to the experience exhibit on which this information is collected. There may be areas that we need to take a look at and the NAIC is fully prepared to entertain comments on that.

In addition, preliminary recommendations have already been made to establish an examiner team which is similar to the examiner team which comes in and looks at insurance companies in general and makes recommendations on which lost ratios should be reexamined or looked at a little more closely. We are in the preparation stages of that activity as well.

Finally, an education program which would contain all of these items is being considered for implementation and for use by the States.

The **Chairman**. Thank you. Senator Cohen.

Senator **Graham**. Excuse me, Mr. Chairman. Mr. Taylor made a comment that I would like to address.

You mentioned the increase in Medigap premiums after catastrophic was repealed. What would it cost a consumer in Arkansas to purchase a Medigap policy which would provide essentially the same extended benefits that catastrophic would have provided?

Mr. **Taylor**. Senator, I'm sorry, I can't give you an exact quote, again simply because different companies have different loss experience and different utilization. To do an average figure, I can't tell you because it just depends on how much volume they have and how credible their data is.

Every company has to file their loss ratios with the right filing and they must be actual loss ratio results, not projected as it was previously, so we review those when we review the rates and the rate filings. You were speaking in terms of premiums, I thought?

Senator **Graham**. Yes. As a customer, if I was to go into the marketplace in Arkansas and say, I want to buy a policy that will give me the same benefits that I would have had under catastrophic, what would it cost me to purchase that policy?

Mr. **Taylor**. Again, Senator, that depends on the insurer and that specific insurer's experience. I may have more premium, but I may have a worse loss situation. If I have more losses, I am going to have to raise my costs accordingly.

With 300 or 400 carriers in the State selling that product, there is an average cost—I'm sure there is an average cost for all of those companies for the minimum benefits, but I wouldn't know which policy it would be, nor which price to quote you.

The **Chairman**. As a follow-on to Senator Graham's question, I think that is a very, very legitimate question and possibly your association could do a little research out there to come up with say an average cost for a policy that would replace the same benefits that catastrophic would have had, had catastrophic continued to be on the books.

Could we now move to Senator Cohen? He might want to catch a part of the joint session. Senator Cohen?

Senator **Cohen**. Thank you, Mr. Chairman.

Mr. Hildreth, you talk in your statement about the need to standardize insurance policies, particularly with reference to definitions, policy terms, and time periods of coverage. What wouldn't be standardized under your ideal situation? The premiums themselves?

Mr. **Hildreth**. That's correct. We feel that if you provide some choice for the consumer, but some choice within their ability to grasp the meaning of that choice, then they can choose and insure based on price and service, which is what most consumers and customers would like to do.

Senator **Cohen**. So you would eliminate the option of offering a two month period of coverage versus a three month period of coverage or vice versa? In other words, there would have to be a standardized period of time.

There would be no deviation allowed so there is no confusing patchwork. For example, one policy has a slightly higher premium for $10 a month; an extra 30 days of coverage if for another $12 per month; and you get 15 days of coverage for a third price. That gets to be fairly confusing to most people.

Mr. **Hildreth**. That's right.

Senator **Cohen**. So you would standardize the time frame, the definitions, the policy terms and essentially leave only a question of market efficiency. As such the customers get a lower price depending on where they go. Is that it?

Mr. **Hildreth**. Our emphasis and priority is to eliminate as much confusion as possible. I think those standards would accomplish that.

Senator **Cohen**. As long as there is a significant spread between the Commission on a new policy or renewed policy, you are going to have an incentive to try and get new policies. I think Mr. Taylor indicated that 50 percent commission is the highest offered, Mr. Taylor?

Mr. **Taylor**. No, sir. The second and subsequent year commissions can be—I said it in reverse to the way it's written—100 percent of the first year commission, so if you pay a $100 commission the first year, they must pay a $50 commission the second and subsequent years for a reasonable number of years.

That eliminates the problem of the 60 percent the first year and 7 percent the next years so there is no incentive to go and turn that policy over and sell them a new policy.

Senator **Cohen**. Is there an easier way of doing it, of standardizing the kind of commission one would have between a new policy and a renewed policy?

Mr. **Taylor**. We would support the leveling of commissions.

Senator **Cohen**. As long as you have a differential, it seems to me if it is a significant differential on the renewal versus the new policy, the agents are going to go for the new policy every time.

Mr. **Taylor**. If in fact the agent replaces the policy with another new contract?

Senator COHEN. Right.

Mr. TAYLOR. That new carrier can only pay that agent a renewal rate of commission. They cannot pay that agent a first year commission because that insured already had a contract under these consumer protection amendments. We have eliminated that incentive to turn those policies over.

The CHAIRMAN. Is that true in all States? Is this across the board?

Mr. TAYLOR. It will be, Senator. Those standards were adopted pursuant to the provisions of the Act repealing catastrophic. Some States require legislative action, some do not, so we have a year. Within the next year, that will be in place for all States.

The CHAIRMAN. You also indicated, Mr. Taylor, that the 30-day period to cancel would be made part of the regulations now. The consumer would have 30 days in which to review the policy. The consumer, I assume, is covered during that 30-day period.

Let's suppose at the end of 30 days, they opt to get out. During that time frame in between would they be covered?

Mr. TAYLOR. They would be covered as long as they had the contract and did not cancel it in that 30-day period. That 30-day free look provision has been in existence in all 50 States for several years.

The CHAIRMAN. Are there any circumstances, Mr. Gaiser or Mr. Hildreth, in which you would allow a second Medigap policy?

Mr. HILDRETH. Only to say that duplicate policies are a waste. One policy should be adequate and the first message to any consumer out there is that if you have one policy, it should be good, it should be comprehensive and there should be no need for a second.

Mr. GAISER. I thoroughly agree with that. A duplicate policy would probably be a fraud.

Can I make one comment on this aspect that he made, the comment that Ron made on not paying a new first year commission to an agent?

The CHAIRMAN. Please.

Mr. GAISER. You're going to flood our Judicial Branch of the Government if you do that because the agent is not going to reveal that there is a replacement taking place and we are going to be in the twisting situation. I don't think that is a satisfactory alternative.

I think the only satisfactory alternative would be to have a level commission, the first year commission and the second year commission, and the third year commission all the same. And obviously, as John has mentioned, have the same type of policy would serve this alternative.

Senator COHEN. Mr. Gaiser, if I can just follow with a couple of quick questions.

You indicated that the loss ratio standard is insufficient. I think it is 60 percent individuals and 75 for group coverage now. You would recommend perhaps going up to as high as 80 percent?

Mr. GAISER. Yes, sir.

Senator COHEN. Why has it been so difficult to enforce the existing standards? I think you commented on this. Right now the GAO has done some studies and of the limited number they studied, 64 percent were in noncompliance.

Why is it so difficult to get compliance with an existing standard which you say is inadequate?

Mr. GAISER. I looked at one company in a lawsuit that I was doing and Senator Cohen, this particular company put over $50 million into their tank, into their unassigned surplus tank over a relatively short period of time. I believe the period was 4½ to 5 years. That is a tremendous incentive for a company to abuse something. I think the profit motive is abundant.

Senator COHEN. I know why they are doing it, the question is why is it so hard to detect? Is there something lacking in our regulatory oversight?

Mr. GAISER. No, sir.

Senator COHEN. On an annual basis, we ought to be able to determine whether a company is measuring up to the loss ratios.

Mr. GAISER. I would confiscate the excess reserves.

Senator COHEN. Why aren't we doing it? Is there a problem?

Mr. GAISER. There is no problem doing it, it's just the motivation——

Senator COHEN. Is there a problem detecting it?

Mr. GAISER. No, sir. It's a very easy thing to detect.

I testified in a case—of course I'm not an actuary, as you know from my biography—and I calculated the ratio and the actuary had miscalculated it. I told the court that they had miscalculated it, and the other lawyer decided not to take me on because it was such an easy calculation.

Mr. HILDRETH. Can I follow up briefly with that question because I differ with Ron's response.

I think there is a regulatory problem and the problem has been that the States have not enforced those loss ratios. In Texas, we finally got the State Board of Insurance only last year to say, we lack statutory authority to enforce those loss ratios.

We passed a bill in a special session of the legislature last July giving them that enforcement, but the States have been incredibly lax in attempting to enforce these loss ratios.

Senator COHEN. Are there punitive damages imposed for that now in violation of those standards?

Mr. GAISER. I don't disagree with you at all. I'm 100 percent in agreement with you. If you think I did, you misconstrued what I was saying. The States would have no difficulty enforcing. It would only take the motivation to do it.

The punitive damage aspect, like in the case that I did in Gadsden, the Phillips case, we used the fact that they were abusing this ratio as a measure of punitive damages and the court awarded a $1.8 million judgment against that company, so that essentially wiped away their gain, but only in Alabama unfortunately because the court system doesn't have the ability to take away all of their operations.

Senator COHEN. Just a final question.

Assuming we were to agree with you that the ratio ought to be changed and made much higher in terms of the return to the consumer, will the insurance industry at that point come to us or to the States and ask for an increase in the premiums in order to cover this return, ultimately penalizing the consumer?

Mr. GAISER. We have 2,000 and some odd insurance companies in the United States. I don't know how many of them write Medigap insurance. I would say the higher quality companies are generally not fishing in this particular pond.

There will be a sufficient number of them to compete with each other so that the ethical company and the ethical operator will still be in the market. If there is a need to be filled, they will fill it.

Senator COHEN. I think the biggest problem right now is enforcing what is on the books.

Mr. GAISER. I certainly agree with that 100 percent.

Senator COHEN. Thank you, Mr. Chairman.

The CHAIRMAN. Both of you have used the term "twisting" a time or two, Mr. Hildreth and Mr. Gaiser. Tell me what that means. What is twisting?

Mr. HILDRETH. That is the practice of an agent, in order to get a higher commission, rather than selling a renewal policy, selling a new policy and doing it repeatedly.

Mr. GAISER. He is correct, except there could be an ethical replacement. There is never—you have to use incomplete, unfair comparison in order to twist. Twisting is common law fraud. It's an intentional misrepresentation of a material fact relied upon by the other party and it's the proximate cause of damage.

The CHAIRMAN. Thank you both.

Mr. Taylor, do you have any final comments? We are getting ready in a moment to call our next panel, do you have any comments?

Mr. TAYLOR. No, sir, I don't think so. Thank you, Mr. Chairman.

The CHAIRMAN. I just have a brief comment. I think somehow or another, I don't want to say that there is finger pointing, that the State should do more or Federal should do more, but all I am saying is all of us have to do more.

I am not going to point any fingers but I truly think that we are all going to have to do more and we're all going to have to join together because we are losing this war rather than winning it.

Senator KOHL. Senator Pryor.

The CHAIRMAN. Yes, sir, Senator Kohl.

STATEMENT OF SENATOR HERBERT KOHL

Senator KOHL. I would like to hear your comment, Mr. Gaiser, I thought you said, in your opinion, most people don't need a Medigap policy?

Mr. GAISER. Senator Kohl, if you were to assess the cost benefit ratio of the typical senior citizen, and the fact that 60 percent of the premium is going to be used to provide benefits and 40 percent of it is going to be totally lost; when you figure that you're going to have a 6-month waiting period before your preexisting conditions are going to be covered; and you put this reverse underwriting component in there, this is the absolute worst thing that anybody can do to an American, to go and write your mother a Medigap policy, ask her almost no questions, and then when she gets ready to file a claim in the first 2 years—during the incontestable period—then they'll underwrite it because they don't want to pay to underwrite it when they first write it.

So this 60 percent thing dwindles down to where your mother will be lucky if she gets a quarter back.

Senator **Kohl**. So you are saying that most people who have a Medigap policy, in your judgment, don't even need one?

Mr. **Gaiser**. I absolutely endorse that. That's my statement.

Senator **Kohl**. That is a pretty strong statement.

Mr. **Gaiser**. Yes, sir.

Senator **Kohl**. Mr. Taylor, Mr. Hildreth, do you disagree with Mr. Gaiser?

Mr. **Taylor**. Senator, I think that's the most absurd thing I have ever heard. Obviously, Mr. Gaiser hasn't been to the hospital or the doctor lately. I'm sure not at this forum, and I won't get into it, but I could bring you two dozen witnesses that have been who are senior citizens that would not have any retirement benefits left to live on now if they had not had Medicare supplement policies.

That is not to say that they are all good or that they are all fair, but they are all necessary, in my opinion.

Mr. **Hildreth**. There is a middle ground here, I think. Mr. Gaiser is referring to the value of what people are getting for their money. There most certainly is a need for the coverage that is provided by Medigap supplement insurance.

Senator **Kohl**. I think that is a good explanation.

I'd like to ask another question, Mr. Gaiser and gentlemen. What we have here is an adversarial relationship, nothing unusual. Adversarial relationships exist in commerce, in every day life. Those are sell, those that buy and that is an adversarial relationship.

It is not surprising to me, nor I think to anybody here, to know that those selling do everything they can within the law, and sometimes beyond the law, but it is not unique to this situation.

What is unique is that we are talking about elderly people, people who are not in a position to protect themselves. That to me is what is unique about the Medigap problem. It is not unique in American society that there are sellers and buyers, and the buyer beware because the seller will use everything he can, whether it is moral or immoral. This is not unusual.

However, we are talking about elderly people who cannot protect themselves. It seems to me that finally we need to have a way of seeing to it that every elderly has a chance—and we have talked about it—to be counseled, to hear from somebody who understands this insurance program because it is so complicated.

Until we get there, or if we can get there, the problem will be largely eliminated—not entirely, but largely. Why shouldn't we have every person who signs a Medigap policy before they sign it, have to be shown a list of a dozen different people they can call for counseling or some other way of letting them know that there is at their fingertips a full range of services that can advise them on the policy they are about to sign.

Then they can sign a waiver if they wish, but before they do that, the insurance salesman has to clearly indicate to the customer that you can call thus and thus and thus and a week or 10 days has to go by, they can't sign it immediately, why shouldn't we do that? Mr. Gaiser?

Mr. **Gaiser**. I strongly urge that. I don't believe they should be able to sign a waiver though because insurance agents can talk people into just about anything.

Mr. Taylor made the comment that my comment was absurd. I am a life member of the Million Dollar Roundtable in addition to being an attorney. I am a chartered life underwriter. I made my living selling insurance for over 20 years. I'm proud of the insurance business.

I am not competing with the NAIC or any State or anyone else. I paid my own way to come up here.

There is nothing right about what's happening in the marketing of Medigap supplement insurance when a person can only have a quarter left or whatever it is after an insurance company abuses him.

I personally abhor any company that would go out and prey upon this market of people. As a salesperson, when I owned an insurance company, a small insurance company, I had a man come to me and want me to sell Medigap insurance and I couldn't do it because it didn't have any benefit ratio that would justify my being able to do that.

I applaud your comments. I applaud your desire to want to participate in this problem for our senior citizens. I think you are on the right track. This counseling has got to be a benefit and if the insurance commissioners and insurance companies don't want to step to the table and take on their responsibility, then the Congress is the ultimate responsible party that must decide that. I strongly urge you to do it.

Senator **Kohl**. Any disagreement, Mr. Taylor?

Mr. **Taylor**. No, sir. We have strongly supported this measure for counseling and continue to do so. I would point out again that 95 percent of the premium in the GAO report, which was a fair sampling, met the loss ratio standards.

The States are endeavoring, as Ms. Olson has pointed out, to enforce those standards at a greater degree now. Any time a rate filing is made, those standards are looked at and the actual loss ratios are looked at before any rates are approved.

The largest writer of Medigap insurance in Arkansas maintains a loss ratio of about 90 percent. Mr. Gaiser continues to get these figures mixed up. It's not the 40 percent that's paying the benefit, it's the 60 percent that's paying the benefit. The loss ratio standard is 60 percent and not 40. That is the portion that goes to pay benefits back to the policyholder.

Senator **Kohl**. Are you saying you also think before people sign a Medigap policy, they should be availed of counseling? Are you saying that?

Mr. **Taylor**. Yes, I am saying that.

Senator **Kohl**. You feel the same way. So there is a common agreement on one thing here today.

Thank you very much, Mr. Chairman.

[The prepared statement of Senator Kohl follows:]

Opening Statement of Senator Herb Kohl

Thank you, Mr. Chairman. I think you've done an outstanding job of identifying the problems that senior citizens face when buying Medigap insurance, and I applaud your leadership on this critical issue. I'd also like to welcome two witnesses from my state who are here today, Mr. Jeff Spitzer-Resnick of the Center for Public Representation in Madison, and Ms. Vickie Frost of the Dane County Area Agency on Aging.

As you know, Mr. Chairman, last December I held an Aging Committee field hearing in Wisconsin to examine many of the same issues we will consider here today: namely, the great confusion that senior citizens face when buying Medigap insurance, and the outright criminality of a few unethical insurance agents who prey on older Americans. I was particularly disturbed to hear about older women, living alone in rural areas of the state, who are "befriended", if that is the right word, by insurance agents who then convince them to buy duplicative or useless Medigap policies. When these women are targeted by insurance agents, they can almost always be sold an unneeded product. I believe that the vast majority of insurance agents are responsible and ethical -- they probably provide fine service to their customers. what we are talking about here are the abusers of the system. And senior citizens have a right to be protected against such fraudulent practices.

Marketing fraud is not the only problem facing senior citizens. Even under the best circumstances, buying Medigap insurance is just not an easy thing to do. To make a sound decision, the consumer first needs to understand Medicare itself -- what is covered, what is not. Then a senior citizen must sort through the different Medigap policies for sale in his or her state. Again, this is a difficult job for anyone, although some states -- including Wisconsin -- have taken steps to standardize benefits. This makes policy comparison much easier. Still, it isn't enough. After reading about the Medigap bill that I introduced last month, a man from Brown Deer, Wisconsin wrote:

"I'm not yet one of the 400,000 plus Wisconsin people who have Medigap insurance simply because I have been unable to sort out the myriads of benefits, payment restrictions, premium rates, etc. of insurance companies who are soliciting my business. Even with the Wisconsin State Insurance Commission chart, which I have." He then asked to me help him, and I quote, "select the best Medigap insurance from among the six inch high stack of material now sitting on my house office desk." He complained that he has received three personal sales interviews and "innumerable" sales calls over the phone from 10 insurance companies.

Clearly, senior citizens are being bombarded with information from insurance companies. There is no shortage of agents willing to sell senior citizens Medigap policies. But there is a shortage of services that provide older Americans with help in cutting through the confusion of buying Medigap insurance. We have to change this. There has to be some recourse for the consumer, some objective person with whom a senior citizen can discuss his or her health insurance needs. We have to balance that one-on-one sales situation with one-on-one health insurance counseling.

In Wisconsin, there are two critical safety nets for Medigap consumers: the Medigap hotline and the benefit specialist program. Jeff Spitzer-Resnick and Ms. Frost will be talking about these programs later today, so I won't go into any great detail about these services now. I appreciate the consideration the Chairman has already given to this program in his Health Insurance Counseling bill. A great deal can be learned from the Wisconsin experience.

Again, Mr. Chairman, thank you for holding this important and timely hearing. Although I will have to leave shortly to attend a hearing of the Agriculture Committee on dairy price supports, I will be back as soon as I can.

The **Chairman**. You achieved that agreement, Senator Kohl, and I want to thank you for it. I would like to say Senator Kohl was the first person in the Senate, last year when we started taking apart and shredding piece by piece catastrophic insurance, that particular legislation, with his expert business acumen, who said wait a minute, we are getting ready to have a problem in Medigap. This problem is going to get very, very severe.

We have been working very closely with Senator Kohl for months on developing an approach, how we may really tackle this issue. I am proud to have him as an ally in this. He is not a Johnny come lately on this issue.

Mr. **Gaiser**. Senator Pryor, can I say something too? It's to my advantage as a trial lawyer for the Medigap to continue in its morass because I will blow every one out of the water that I can catch defrauding any of these old people.

I have traveled and testified as an expert witness and there is no amount of money that would keep me out of a courtroom when one of these people does some of the things that I've seen done.

The **Chairman**. Thank you. Ron, thank you. Thank you, John. We will call our next panel. That was a very, very good panel.

We have our next panel, Ms. Bonnie Burns and Jeff Spitzer-Resnick. Bonnie Burns is a consultant to California State Health Insurance Counseling Program and to the local HICAP programs. Mr. Spitzer- Resnick is from the Center of Public Representation, Madison, Wisconsin, a distinguished constituent of Senator Kohl. Mr. Spitzer-Resnick is accompanied by Vickie Frost from the Dane County Benefit Specialist Office. We appreciate you being here.

Bonnie, we will call on you first to make your statement and we look forward to you summarizing that statement, if possible, and then we will have some questions.

STATEMENT OF BONNIE BURNS, CONSULTANT, CALIFORNIA STATE HEALTH INSURANCE COUNSELING PROGRAM AND LOCAL HICAP PROGRAMS

Ms. **Burns**. Thank you, Mr. Chairman and members of the committee.

I, too, want to commend you on your opening statements. I agreed with everything that you said. It is always interesting to listen to the people on the panel who precede me because I can barely restrain myself from jumping up and down while they are testifying.

The rate increases that we have seen in Medicare supplement insurance are the same rate increases that occurred when catastrophic came in when everyone expected the rates to drop. They didn't drop, they went up. They went up again this year and I don't think anyone in living memory can remember a time when Medicare supplement insurance premiums have dropped.

In one year they remained stable for about a 9-month period but very few people can remember a decrease in votes.

During the last decade, numerous hearings have been held in Congress because abusive sales insurance practices committed against seniors continue unabated. They are a pervasive national scandal.

Marketing and sales abuses are possible precisely because the policies sold to seniors are purposefully incomprehensible in their language and construction. Medicare supplement policies defy side by side comparison, and even singly are impossible for seniors to understand.

Some companies deliberately encourage agents to use tactics of fear and intimidation. I direct your attention to a chapter taken from a product training manual from Standard Life and Accident Insurance Company of Oklahoma City. I believe this document is included in your materials.

The chapter is entitled, "Your Key to Professional Selling," and it was obtained through discovery and is part of the public record.

Agents are expected to memorize this document as you can see from the opening letter written by Thomas Poteet, Jr., identified as Assistant Vice President and Assistant Vice President of Marketing.

On page four, the agent is directed to use the following sales pitch:

> Hello, my name is (insert your name). I am with the Survey Division of Standard Life and Accident Insurance Company. We are taking a survey of hospital insurance coverage in this area.

Such a representation is a violation of law in many States, including California where it was used. On page one, the agent was directed to speak loudly and rapidly and on page five, instructed to say, "May I step in for a few moments," with an admonition printed in capital letters "TO MOVE." The implication of not waiting for consent is clear.

On page 12, he is told to stall his prospect because by putting him off, he will forget his objections anyway. These printed instructions are all the more outrageous because this company sells quite a lot of insurance to older people.

Sales standards such as these have been accepted in the industry for too long and they fuel the abuses of overselling and twisting you have all heard about for years, yet when legal or administrative actions are filed against agents for using these tactics, companies hide behind the independent contractor status of the agent. They deny any knowledge or responsibility for the very practices they have encouraged through training or by implication.

There are enormous gaps in administrative procedures and criminal and civil law, the laws are just not there. Prosecution of these cases is very difficult when they depend on an elderly witness having clear, exact and unshakable recall of events and conversations which occurred more than 3 years in the past. Administrative actions are inadequate remedies at best and tortuous at worst.

One remedy that has been successful is the availability of third party counseling. Our statewide insurance counseling program served 5,000 people in the last fiscal year who had documented client savings of more than twice the $2 million annual cost of the program.

One local HICAP agency has reported savings equal to four times their annual grant allocation. Community education and one-on-one counseling by more than 600 trained volunteers has resulted in a sharp decrease in the numbers of California seniors who now purchase multiple and duplicative coverage.

In 1989, I was an expert witness in a remarkable case filed by the District Attorney of Santa Cruz County against Bedrossian Insurance Agency, Inc., of San Jose, California for overselling insurance to hundreds of seniors.

The case was the result of a single victim discovered by a local HICAP agency. The colorful bar graph chart on display is an exhibit from that case. On the bench you have six other marked exhibits from that case.

We made a chart for each elderly victim presented in the case. Each chart represents all of the policies sold to that senior, usually by a single agent. Each colored line indicates the type of insurance, such as medical, life, nursing home insurance, the date of the sale and the length a particular policy was in force.

The CHAIRMAN. Ms. Burns is that the chart here on the wall?

Ms. BURNS. That is the chart on the wall. The yellow bars are all the medical insurance, the red bars are all the life insurance, and the blue bars are all of the nursing home insurance sold to that individual.

I want to remind you in the discussions about Medigap, loss rations, and premium increases, that we are talking about a whole range of policies. Medicare supplements are only one of them. All the rest of these garbage policies have loss ratios that are truly shocking.

Last week, the California Department of Insurance began an administrative hearing against another agent, Ed Chernecki of Santa Rosa, for similar sales practices, including the sale of 34 policies to an 89-year-old man and his wife that cost the couple $36,000 over a 4-year period. The victim and his wife have an income of $500 a month.

A quick call to a neighboring State to ask if Mr. Chernecki was licensed to sell insurance in that State, as had been rumored, elicited a negative response. They had no record of an application or knowledge of his activities as an agent, yet he has prominently advertised his insurance services in a telephone book in that State since at least February 1989.

The NAIC has a voluntary, interstate system for reporting bad agents, but it is woefully inadequate. The District Attorney in the California county where Mr. Chernecki did most of his selling has declined to consider a case against him for fraudulent and abusive sales practices. That is not unusual.

To make matters worse, if that is possible, Mr. Chernecki has sued the advocate of the HICAP agency who reported these abuses to the California Department of Insurance. We have been fortunate enough to get a pro bono attorney for this lady, but if we had had to pay for those services, we would have incurred costs of over $20,000 at this point in the case.

There are two similar administrative actions pending in the Department of Insurance against other agents and agencies from Northern California communities for similar practices that are scheduled for hearing after the conclusion of the Chernecki hearing.

None of these cases, including the Bedrossian case and all of the agents involved, will meet a criminal standard for prosecution. They have not and will not be considered for prosecution under any criminal statute.

Many of the complaints which resulted in these administrative actions were reported by the victims to a counseling program. The counseling program then developed the complaints and filed them with the Department of Insurance on behalf of their elderly clients.

I have been an outspoken critic of the California Department of Insurance for its failure to take strong action against these abuses. These recent cases, by the way, are an anomaly. It's been very difficult to get administrative actions filed in cases such as these.

The Chernecki case is a good example of ineffective regulation. Here is an agent who was granted a restricted license in California in lieu of revocation in 1979. That license was subsequently suspended for 90 days and while it was suspended, he continued to transact insurance business in California, and in fact was on a restricted license at the time these abuses were committed.

It has taken from 1979 until 1990 for the current hearing on his license to take place. If this is an example of a State that is generally viewed as having strong enforcement, I shudder to consider what may be happening in other States.

Back in 1980, the Congressional Quarterly Weekly Reports, in a story about sales abuses, published a quote from insurance industry officials responding to the problem of sales abuses, "Lawmakers and journalists have blown a fringe problem out of proportion and that States are now moving to correct it anyway," bear in mind this was 1980.

In every Federal hearing held since then, the industry has reiterated that position. They continue to refuse to acknowledge that these abuses occur. Public-awareness and outrage is a gathering storm for which the industry has no one else to blame.

It is time for the Congress to take strong action on these abuses. We can pass all the laws that we care to in the States or at the Federal level, but if enforcement and penalties are not there, and administrative will is not there, these abuses will continue, and I will see you again in the year 2000.

I urge you to consider statewide insurance counseling programs as the only effective means of helping seniors avoid the very clever perpetrators of economic rape who are so willing to prey on the trust of our elderly citizens.

Thank you for the opportunity to testify.

[The prepared statement of Ms. Burns follows:]

BONNIE BURNS
MEDICARE SPECIALIST AND CONSUMER ADVOCATE
21 LOCKE WAY
SCOTTS VALLEY, CA 95066
408-438-6677

MARCH 7, 1990

Mr. Chairman, members of the committee. I am here representing the California Association of HICAP programs. HICAP is our statewide Health Insurance Counseling and Advocay Program. The state program has twenty four local contracting agencies that provide insurance counseling services to seniors.

During the last decade numerous hearings have been held in congress because abusive insurance sales practices committed against seniors continue unabated, and are a pervasive national scandal. Marketing and sales abuses are possible precisely because policies sold to seniors are purposefully incomprehensible in their language and construction. Medicare supplement policies defy side by side comparison, and even singly are impossible for seniors to understand. When added to the full array of garbage polices that can be sold in the same sales session a climate of fear and confusion is very easy to create.

Some companies deliberately encourage agents to use tactics of fear and intimidation. I direct your attention to a chapter taken from a Product Training Manual from Standard Life and Accident Insurance Company of Oklahoma City. I believe this document is included in your materials. The chapter is entitled "Your Key to Professional Selling."

Agents are expected to memorize this document as you can see from the opening letter written by Thomas Poteet, Jr., identified as the Assistant Vice President and Assistant Vice President of Marketing.

On pg. SP-4 the agent is directed to use the following sales pitch. "Hello. My name is_______________ I'm with the Survey Division of Standard Life and Accident Insurance Company. We're taking a survey of hospital insurance coverage in this area."

Such a representation is a violation of law in many states, including California where it was used. On pg. SP-1 the agent was directed to talk "loudly" and "rapidly", and on SP-5 instructed to say "May I step in for a few moments?" with an admonition printed in capital letters to MOVE; the implication of not waiting for consent is clear. On pg. SP-12 he is told to stall his prospect "because by putting him off he'll forget his objections anyway."

The "Fear Close" on pg. SP-11 is one in which the agent reminds the prospect of the millions of dollars spent each year on hospital bills and personalizes that fear by using the prospect's income as a dramatic example of loss. These statements are all the more outrageous because this company sells a lot of insurance to seniors.

Sales standards such as these that have been accepted in the industry for too long, and they fuel the abuses of overselling and twisting you have all heard about for years. Yet, when legal or administrative actions are filed against agents for using these tactics companies hide behind the independent contractor status of the agent. They deny any knowledge or responsibility for the very practices that have been encouraged through training or by implications.

There are enormous gaps in administrative procedures and criminal and civil law which make prosecution of these cases very difficult when they depend on an elderly witness having clear, exact and unshakable recall of events and conversations which occurred more than three years in the past. These are inadequate remedies at best and tortuous at worst.

One remedy that has been successful is the availability of third party insurance counseling. Twelve states now offer some type of counseling in direct response to these intractable sales abuses to help people understand and compare their insurance needs and benefits.

In 1983 and 1984 I worked on state legislation in California which eventually resulted in HICAP, our statewide insurance counseling programs for seniors. HICAP served over 5,000 people in the last fiscal year and documented client savings of more than twice the $2,000,000.000 annual cost of the program. One local HICAP agency has reported savings equal to four times their annual grant allocation. Savings are achieved primarily through assistance with claims and refund of premiums for duplicative and unnecessary coverage. Community education and one on one counseling by more than 600 trained volunteers has resulted in a decrease in the numbers of California seniors who now purchase multiple and duplicative coverage.

In [illegible] I was an expert witness in a remarkable case filed by the district attorney of Santa Cruz county against Bedrossian Insurance Agency, Inc., of San Jose California for overselling insurance to hundreds of seniors. The case was the result of a single victim discovered by a local HICAP agency. It was successfully settled for a $700,000.00 judgement and a permanent injunction against future sales. The colorful bar graph chart on display is an exhibit from that case. We made a chart for each elderly victim presented in the case. Each chart represents all of the policies sold to that senior, usually by a single agent. Each colored lines indicates the type of insurance such as medical, life, nursing home insurance, and the date of the sale and the length of time a particular policy was in force.

Last week the California Department of Insurance began an administrative hearing against another agent, Ed Chernecki of Santa Rosa, for similar practices, including the sale of 34 policies to an 89 year old man and his wife that cost the couple $36,000.00 over a four year period. The victim and his wife have an income of $500.00 a month.

Their savings, which were $65,000.00, financed the cost of these policies. Mr. Chernecki completed the applications and made out the checks for this elderly couple. The victim, testifying at the hearing, said that his vision is very poor and he signed where Mr. Chernecki told him to sign. They did not know they had purchased 34 policies. Mr. Chernecki committed all of his current abuses while holding a restricted license, issued in lieu of revocation, as a result of prior action taken by the department.

A quick call to a neighboring state to ask if Mr. Chernecki was licensed to sell insurance in their state, as had been rumored, elicited a negative response. They had no record of an application or knowledge of his activities as an agent, yet he has prominently advertised his insurance services in a telephone book in that state since February of 1989. The NAIC has a voluntary interstate system for reporting bad agents but it is woefully inadequate.

The district attorney in the California county where he did most of his selling has declined to consider a case against him for fraudulent and abusive sales practices. To make matters worse, if that is possible, Mr. Chernecki has sued the advocate of the HICAP agency who reported these abuses to the California Department of Insurance.

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Many of the complaints which resulted in those administrative actions were reported by the victims to a counseling program. The counseling program then developed the complaints and filed them with the Department of Insurance on behalf of their elderly clients.

I have been an outspoken critic of the California Department of Insurance for its failure to take strong action against these abuses. The Chernecki case is a good example of ineffective regulation. Here is an agent who was granted a restricted license in California in lieu of revocation in 1979; that license was subsequently suspended for 90 days when it was discovered that he had failed to disclose to the California Commissioner that he was fined in a disciplinary action in the state of Oregon where he was previously licensed.

While his license was suspended he transacted insurance business in California, sent an application for insurance to a company without the knowledge and consent of the applicant, and used the proceeds of a refund from a previous sale to pay the initial premium for the unwanted coverage. In 1982 he took applications for insurance to a company with which he was not authorized to do business. It has taken from 1979 until 1990 for the current hearing on his license to take place! If this is an example of a state that is generally viewed as having strong enforcement I shudder to consider what may be happening in other states.

Back in 1980 the Congressional Quarterly Weekly Reports, in a story about sales abuses, published a quote from insurance industry officials ..."that lawmakers and journalists had blown a fringe problem out of proportion and that states were now moving to correct it anyway." In every federal hearing held since then they have reiterated that position.

The industry has shot itself in the foot by refusing to acknowledge that these abuses occur and for failing to clean their own house. Public awareness and outrage is a gathering storm for which the industry has no one to blame but itself.

I urge you to consider statewide counseling programs as the only effective means of helping seniors avoid the very clever perpetrators of economic rape who are so willing to prey on the trust of our elderly citizens.

Thank you for the opportunity to testify here today.

Bonnie Burns

The **Chairman**. Thank you for your eloquent statement.

Mr. Resnick, thank you for coming here.

STATEMENT OF JEFF SPITZER-RESNICK, CENTER FOR PUBLIC REPRESENTATION, MADISON, WI, ACCOMPANIED BY VICKIE FROST, DANE COUNTY BENEFIT SPECIALIST

Mr. **Spitzer-Resnick**. Thank you, Senator Pryor.

I am coming here from the Center for Public Representation which is a non-profit, public interest law firm located in Madison, Wisconsin. We are dedicated to representing the rights of the unrepresented and the underrepresented including, among other groups, the elderly.

We have extensive experience in this area both through advocacy and through representation of the elderly. I will introduce towards the end of my talk, Vickie Frost, one of our Benefit Specialists who has been involved in counseling seniors.

In my testimony, which I hope you will take a look at, I have listed ten specific problems with proposed solutions. In order to keep my testimony brief, I will only highlight the most critical ones that have not been addressed by other witnesses today.

I would like to emphasize, however, that the Senate and the House of Representatives ought to recognize this is a problem the Federal Government created. Had it created a Medicare program that did not need Medicare supplements, we wouldn't be here today, so I think the Federal Government has a peculiar and particular responsibility to solve this problem, albeit with the help of States. I do not think it can shirk its responsibility.

Let me list and propose solutions to a number of severe problems that have not been discussed today. The first one is out of State marketing abuses.

While you've heard many problems about agents going door-to-door, the other problem which we haven't heard mentioned today is what you might call your typical celebrity advertisement on TV. We have seen clients with as many as 13 different policies and we have said to the client, "who is your agent? We want to go after your agent." They said, "Oh, I just dialed 1-800."

There is no enforcement or checking. Most States do not enforce on these policies because they are not located in that State. To me the only way we can have control over these policies is to have the FTC, the Federal Trade Commission, develop regulations to restrict the use of toll free hotlines to give States authority if they don't already have it, to regulate any policy sold in their State whether or not it comes through a toll free hotline.

Finally, the FCC, I assume, already has authority to restrict advertising which is blatantly false. I have, myself, heard advertisements which say if you buy our Medicare supplement, you will never have another out-of-pocket cost again.

I assert to you there is no such a Medicare supplement in the entire United States of America, so any statement such as that is an out and out lie and the FCC should prosecute that.

The second point that I would like to make is what I would call not just the high rates of Medicare supplements but the gross rate disparities.

Behind Senator Kohl is a chart that we prepared from the State of Wisconsin listing not the five most popular policies but five of the most popular policies to illustrate. While they aren't the highest and lowest, this is a range.

Unfortunately, our NAIC representative couldn't give you a range. I will give you the range from Wisconsin. For a 65-year-old woman in Milwaukee—keep in mind one of the reasons this is confusing is many companies sex rate, they age rate, and they location rate, so that chart would look different if you were in Madison, it would look different if you were a man, it would look different if you were 85-years-old, so this is just a general example.

For a 65-year-old person, we have a range form $454 to $861 and for a 75-year-old, $591 to $1,017. These are annual premiums and what I would like to emphasize is every premium there is for the exact same policy, no difference in benefits.

I will readily admit that in some of those policies you may have a difference in service and you may have a difference in payout. In other words, there may be a policy in there, and I'm not going to testify that, that illegitimately does not pay a benefit that they ought to pay.

Considering the size of these companies—and I heard Mr. Taylor from the NAIC state that they have different loss experiences, well I would like it explained to me that when you sell multimillion dollars' worth of premiums, that ought to average approximately the same.

I can see differences, $10, $20, maybe even $100, but when you have literally close to double premiums, I don't know how that can exist. My feeling is loss ratios not only must be increased but they must be strictly enforced.

As an attorney, and I will compliment Mr. Gaiser on his techniques, I would not like to, since I would be too busy, have to sue every insurance company that doesn't comply with loss ratios.

What I'd like to do is sue the State insurance commissioner for not enforcing probably one-third of the companies' loss ratios.

When Senator Kohl was in Wisconsin at a hearing on this matter, he asked our insurance commissioner about five different cases with as low as 23 percent loss ratios, and to every policy the insurance commissioner had an excuse.

Do you know what the excuse is in actual fact? I found this out from an employee of our insurance commissioner, whose name I will not reveal for fear of her job, our insurance commissioner—the Wisconsin Insurance Commission is considered one of the best in the country—doesn't have a person who is a trained actuary.

When an insurance company delivers it loss ratio, the insurance commissioner says, it looks pretty good. It might be over 60 percent, might not be, but there is no way the insurance commissioner even has a single person—the person who has the title of actuary doesn't even know how to use a computer. That to me is relatively frightening.

Point three is nonstandardized benefits make cost comparisons impossible. I would be glad at another time to share with you the Wisconsin experience on standardization. I think it has worked rather well.

The only modification I would make on standardization in Wisconsin is what we have is a standard minimum packet and then we have specific riders with premiums that people can choose. They can choose to purchase the Part B deductible. They can choose to purchase home health, and there is a cost tag attached.

It is very good because the person sees how much it's going to cost. We had one company that was charging $99 for a $75 Part B deductible. The insurance commissioner approved that mind you. We finally convinced them they ought not approve that.

I think the only modification I'd make is that the loss ratio should be provided for each and every rider so that when a company says, we're charging $99 for a $75 deductible, we can ask them, "can you show us what your loss ratio is on that?" Quite obviously it could not be 60 percent.

Finally, I would like to mention that in regard to counseling—and I'll turn it over shortly to Vickie Frost—is that poorly trained agent sales pitches misinform the public. We've heard much about this.

Agents, whether they are legitimate or illegitimate, even the best ones, need training. We know we have a Medicare problem in terms of people understanding Medicare. You can't buy a Medicare supplement if you don't understand Medicare. You can't sell a Medicare supplement if you don't understand Medicare. Agents must be trained, even the good ones.

Even more important of course is counseling. I will turn it over to Vickie Frost to talk about Wisconsin's Benefit Specialist system which has been in existence for over 10 years.

[The prepared statement of Mr. Spitzer-Resnick follows:]

Center for
Public
Representation

121 South Pinckney Street Madison, WI 53703 608/251-4008

TESTIMONY OF ATTORNEY JEFFREY SPITZER-RESNICK
CO-DIRECTOR, ELDERLY DEPARTMENT, CENTER FOR PUBLIC REPRESENTATION
and VICKIE FROST, DANE COUNTY BENEFIT SPECIALIST
before the U.S. SENATE SPECIAL COMMITTEE ON AGING

March 7, 1990

The Center for Public Representation appreciates the opportunity to present testimony to your Committee today. The Center is a non-profit, public interest law firm located in Madison, Wisconsin, representing the rights of traditionally unrepresented and underrepresented individuals and groups, including the elderly, health care consumers, families, and women. We have extensive experience in Medicare supplement issues, through the operation of our lay advocate legal assistance program for the elderly, known as the "benefit specialist" program in Wisconsin, as well as our national training contract on these and other issues with the American Association of Retired Persons (AARP).

We have been asked today to suggest areas for federal action in Medicare supplement legislative and regulatory reform, and we are pleased to do so. We find it encouraging, first and foremost, that this Committee recognizes that the federal government's long-standing deference to the states on matters of insurance can no longer be tolerated, at least in the area of Medicare Supplement insurance. Medicare supplements are, of course, tied to Medicare -the federal government insurance program and, given Congress' constant changes to the Medicare program - nowhere more painfully evidenced than the on-again, off-again Catastrophic program - the federal government must take the lead in regulation of the Medicare supplement insurance market.

We would like now, to identify ten problem areas that we have noted in Wisconsin over the years and propose solutions for your consideration.

(1) Inappropriate Replacements - The changes resulting from Congressional action on the Catastrophic program have only exacerbated the long-standing problem of unscrupulous agents making inappropriate replacements, which results in beneficiaries being subject to higher premiums, new underwriting conditions, and new waiting periods for pre-existing conditions. PROPOSED SOLUTION - The federal government must put limits on the first-year commission to agents, which we believe is the main motivator of these sales. The limits should take the form of requiring insurers to pay their agents the same commission for an initial policy as they do for a renewal. This will eliminate the agents' incentive to unnecessarily replace consumers' Medigap policies. Additionally, there must be strong regulations on "suitability", including the replacing company sending a notice to the current insurer, and stiff penalties for violations.

(2) Out-of-state Marketing Abuses - State governments have little or no control over the type of celebrity endorsement and invitation to toll-free phone line types of television pitches, which result, in our experience, from consumers often purchasing on their own excessive numbers of policies. PROPOSED SOLUTION - The FTC should be given regulatory authority over this area and should develop regulations which restrict the use of toll-free phone lines and require such companies to comply with the replacement rules of the state in which they are marketing. Moreover, Congress should demand that the FCC enforce its truth-in-advertising regulations against Medigap insurers who regularly and falsely claim that if a senior citizen purchases their policy they will never have another out-of-pocket medical expense again.

(3) Mid-policy Term Right to Cancellation and Refund - Many companies require three, six, or even twelve months' premium at one time, and then refuse to refund any prepaid premium when a policyholder cancels during the policy's term. PROPOSED SOLUTION -Federal law should require companies to refund consumer premium upon 30 days' notice of cancellation by the insured.

(4) Gross Rate Disparities - As the attached charts clearly demonstrate, companies selling the same policy have rates varying by over 200%. The percentage of premium increases each year also clearly demonstrates the need for improved rate regulation. This issue, too, has been heightened by Catastrophic. Last year at this time, companies told us that "Catastrophic wasn't adding that many benefits" so their policies still would increase, although not quite as much as they otherwise would have. This year, the New York Times (10/25/89) reports, and Wisconsin experience confirms, that insurers assert that, with the repeal of Catastrophic and the burden of these benefits being returned to the Medigap insurers, premiums will increase by, in some cases, as much as 76% In fact, our office has already received complaints of consumers receiving retroactive rate increases to allegedly cover the costs of the loss of Catastrophic benefits. Without meaningful rate regulation, some insurance companies appear to be making a huge profit on the backs of some understandably confused Medicare beneficiaries. In Wisconsin, we have no rate regulation, other than use of a "loss ratio" - i.e., companies are to pay out $ .60 of every $1.00 collected. We do not believe the Wisconsin Insurance Commissioner is adequately enforcing this requirement. PROPOSED SOLUTION - The federal government should require state insurance commissioners to vigorously enforce loss ratios, applying them to each benefit (where benefits are provided by riders), publicizing annually the loss ratios for each of these companies, and requiring annual notice to each policyholder.

(5) Non-standardized Benefits Make Cost Comparisons Impossible. Wisconsin has made important strides in this area in the last year by requiring a standard basic policy, with additional benefits to be provided by rider. This has greatly reduced the "comparing apples and oranges" problem. PROPOSED SOLUTION - The federal government should make such standardization mandatory in all states.

(6) The Continued Sale of Dread Disease and Indemnity Plans Results In Consumers' Spending Limited Dollars for Health Care Inefficiently. The purchase of "cancer insurance" and hospital indemnity policies is, in almost all cases, duplicative of Medicare and therefore a waste of premium dollars. PROPOSED SOLUTION - The federal government should follow the lead of several states in banning the sale of these generally duplicative policies.

(7) Poorly Trained Agents' Sales Pitches Misinform the Public. A Medigap agent MUST possess an extensive knowledge of both Medicare and Medicaid law in order to competently and accurately present a Medigap policy's value to a consumer. PROPOSED SOLUTION - The federal government should require specialized initial, as well as continuing education training for agents in this area. State insurance commissioners should be required to develop and conduct these training programs so as to both avoiding putting this responsibility on companies, and to ensure accurate, consistent information.

(8) State Enforcement and Complaint-Handling Is Inadequate. Unfortunately, Wisconsin is a good example of a state in need of improved enforcement and complaint-handling. Our insurance commissioner, and those of other states, must have the authority to make individuals whole, by returning premium dollars and requiring payment on inappropriately denied claims. Consumers must be given a clear private right of action under the insurance code, and consumer protection laws must not exempt insurance. Toll-free complaint lines must be staffed by consumer-friendly, real people, and enforcement efforts must show the public that more than wrist-slapping is going on. PROPOSED SOLUTION - The federal government should require toll-free complaint lines in every state, should make clear that all consumer protection laws apply with full force to insurance matters, should establish a private right of action for consumers, and should enact systematic, clear standards for penalties for violations. Regular publication of insurance department enforcement efforts should be made to the public, and copies should be sent to the state Medigap Hotline.

(9) Mandated Benefits Are In Some Cases Only Phantom Benefits. In coverage areas where Medicare does not have the traditional "cost gaps", Medigap coverage must, by definition, provide more generous coverage (i.e., less restrictions/conditions for coverage) or the benefit will be meaningless. An example of where we believe such is currently the case in Wisconsin is home health care. PROPOSED SOLUTION - The federal government must carefully look at mandated benefits and provide states with the directive, and tools, to ensure that such benefits are actually paid out. Some ideas include, selected claims review by the state, enforcement of loss ratios on the benefit, review of policy criteria, and strengthened regulation.

(10) Lack of Consumer Education Continues to be a Major Problem Resulting in Poor Insurance Choices by Consumers. Wisconsin is also in the forefront in this area by having developed consumer brochures (with required agent distribution), comparison charts available to the public, a toll-free Medigap Hotline staffed by knowledgeable, objective counselors, and a county-by-county benefit specialist counseling program. **PROPOSED SOLUTION** - Such initiatives should be required by the federal government in every state. We wholeheartedly support the bill recently submitted by Chairman Pryor (S. 2189) entitled the "Health Insurance, Counseling, and Assistance Act of 1990" which would begin to address the gap in consumer education in this problematic area.

CASE EXAMPLE

This past January we assisted a client who felt uneasy about a Medigap policy she had purchased December 26, 1989, which as you recall, was just after the repeal of Medicare Catastrophic Legislation. An agent had come to her home and sold her a Medicare supplement to replace the HMO she was enrolled in at that time. She gave him a check for $876.00 to cover the cost of the premium for the upcoming year. She did this because she was told if she did not pay for twelve months of coverage at that time, the premium would be considerably more costly. The check had cleared this person's account two weeks after it was written, and on the morning of January 30, 1990, she still had not received a copy of the policy she had purchased. Her concern and confusion over the changes in Medicare coverages and the fact that she had been talked into writing a large check that was immediately cashed, and the fact that she still had no policy, made her feel uneasy. She, therefore, decided to call our office to speak to a benefit specialist for assistance. Upon investigating this case, these are the facts that were uncovered by the benefit specialist:

1) The policy sold on December 26, 1989, and subsequently delivered to this person on the afternoon of January 30, 1989, was not approved for sale in Wisconsin. Mrs. S. asked the agent directly if this policy was approved for sale in Wisconsin when he delivered it to her. The only answer he would give her was that this was a "new" policy.

2) The information given to Mrs. S. at the time of the sale was outdated and contained only information about coverages under Catastrophic Care legislation, which by December 26, 1989, had been repealed.

3) Enrollment in the HMO did not expire until April of 1990 and it was not possible to get premiums refunded from this HMO. This person was going to have duplicative coverages for this period of time.

4) Enrollment in the local HMO provided coverages for all approved Medigap costs for only $5.00 per month more than the replacement policy, which would have left our client with out-of-pocket Medigap costs.

This agent also had taken the initiative to previously sell Mrs. S. a virtually worthless nursing home policy with very restrictive coverages. He also mentioned to Mrs. S. the names of several other people she knows personally that he had sold this policy to in December to persuade her to replace her HMO with the new policy. The confusion over the repeal of Catastrophic legislation and the fear of large increases in premiums was also used as leverage to make this sale.

The most frustrating part of this case was knowing this agent had by his own admission, sold the same policy to many other people in his community. After filling out a complaint form to send to the Wisconsin Office of the Insurance Commissioner, Mrs. S. called our office to speak to the benefit specialist the Monday following our contact. She told us she was pressured by family and members of her church that this agent also attends, and planned to drop the complaint against him. It would have been very helpful to have been able to pursue a complaint against this agent without needing Mrs. S.'s statement and to know that when we did, there would be definite consequences for this agent because of his improper actions.

This is one example of many problems we have seen in working in the aging network in our local community. It has been a long standing, frustrating problem that has only gotten worse over the past few years.

We would be happy to answer any questions the Committee might have regarding our testimony, and again, we wish to thank the Committee for its invitation to participate today.

Ms. **Frost**. Thank you for allowing us to come and testify today, Senator Pryor.

In the written testimony, there is a case example of an experience that I just had recently in January, but we decided with all the talk today about the counseling services, my time might be better served by telling you what the benefit specialists do in Wisconsin.

I'd like to start by addressing the point that Senator Warner made that if we're going to put these counselors out in the States, that they not just counsel people on Medigap insurance policies.

I think that is a unique aspect of our benefit specialist program in that we are trained and we have on-going training each month to keep us up-to-date on changes in all Government entitlement benefit programs that affect our senior citizens.

We are aware of the Supplemental Security Program, the Medical Assistance Program, what is going on with the Social Security Administration and Medicare. Of course in companion with Medicare, we also counsel our people on the Medigap insurance.

I think another important aspect of that is in light of all the discussion today about the costs of these Medigap policies and that a lot of people out there can't afford them, by being professionally trained in these other areas we can also assist someone who is eligible for medical assistance or SSI in getting on those programs rather than spending money that they don't have for a Medigap policy.

I think another unique aspect of our program is that we are county-based. There are benefit specialists in each county, so we are known locally. We network very actively with other agencies that service the aging network in our counties so that we are identified as the professional experts to be contacted also by other agencies not only just by clients.

We feel that we also, besides providing one-on-one information, counseling and advocacy, are also helping educate the public and other people working in the aging network so that the more education and information we can get out there, the more education, information, advocacy everyone is doing for our senior citizens.

Thank you.

The **Chairman**. Thank you, very, very much. We appreciate the statement of all three of our witnesses this morning.

I want to ask, Mr. Resnick, tell me about this particular chart. Do other States have such charts like this?

Mr. **Spitzer-Resnick**. I will say two things about the chart. The chart was culled from a chart that the Wisconsin Office of the Commissioner of Insurance, the OCI, puts together. That chart, as I viewed it—and I've traveled quite a bit in this country and seen other charts as they exist in other States—Wisconsin's chart is probably one of the best charts.

This is not the chart that you're looking at because the Wisconsin chart—I'd be glad to show you one afterward—is relatively difficult for a consumer to understand. Most States do not even have what you are looking at for even the most popular five policies in their State.

I would argue if we do even the most minimal thing for consumers, this would be a very minimal thing to do. I think a lot more needs to be done but your average consumer can look at this and say something is wrong here when one policy costs nearly twice as much as another for the exact same policy, or investigate and find out perhaps in this case Blue Cross has much better service than American Family, the question can be asked.

The **Chairman**. Ms. Burns, do you want to comment on this?

Ms. **Burns**. Yes. We did compare policies in California, both the Department of Insurance has done so and, private individuals have done it and we do some comparisons through our HICAP program.

It is inconceivably impossible to do this because there are over 200 policies that can be purchased in California, not including group policies, and employer group policies. They are so impossible in their construction that you are comparing apples and oranges.

What you end up with is that you identify those things that you can readily compare and at the bottom of the chart, you have a zillion asterisks to indicate certain variations in a particular policy that is different from the others.

Mr. **Spitzer-Resnick**. I would like to add that the only reason we were able to put a chart like this together is because Wisconsin has relatively standardized benefits. If we move nationally to standardize benefits, then something like this would be very simple to put together in every State.

The **Chairman**. Do both of your States have the Medigap 1-800 hotline in California and in Wisconsin?

Ms. **Burns**. Yes. In our State they refer those calls to HICAP.

The **Chairman**. What about Wisconsin?

Mr. **Spitzer-Resnick**. We have it in Wisconsin and what I would like to add is, as much as I think the Benefit Specialist Program is an excellent program, I think it's important to have it in combination with the toll free line because there are seniors that we can't reach. They are isolated. For all our outreach efforts, they don't find out about us.

To the insurance commissioner's credit, every insurance agent when they sell a policy or even market a policy to a consumer, they must give them a little booklet from the Commissioner of Insurance which is Health Insurance Advice for Senior Citizens.

On the front in bold print is the Medigap hotline toll free number. If the hotline counselor thinks they need individual local service from a benefit specialist, we work with her regularly and that arrangement will be made.

I think the two in tandem really provide perhaps the most complete service that can be given.

The **Chairman**. How do you train those volunteers to answer the questions?

Ms. **Burns**. We are not trained volunteers. We are paid professionals.

The **Chairman**. You are paid professionals?

Ms. **Burns**. That's right.

The **Chairman**. But there are trained volunteers in some of these programs that you are speaking of.

Ms. **Burns**. In California, there are both paid staff and trained volunteers. Volunteers go through an intensive training period, a co-counseling period, and they have monthly continuing education requirements. We are just now putting the finishing touches on a certification process.

We do use volunteer counselors and they go through a very intensive training process.

Mr. **Spitzer-Resnick**. In Wisconsin, while some of the benefit specialists have volunteer programs, we feel it is essential that the amount of work to be done and the level of training that is necessary, be done by paid professionals, albeit it often, I'm sorry to say, underpaid due to lack of sufficient funding.

We do have a paid professional at least part-time in all 72 counties in Wisconsin.

Ms. **Burns**. Yes, and that's true in California too. We use the HCFA regional office to do the training on Medicare and we use paid professionals to do other parts of the training from various places in the community.

I would like to point out one thing too while we are talking about this because Jeff brought it up. These sales are made in the home. Many of the sales agents don't have offices, and in fact, we just introduced a bill in our State legislature related to this fact.

One provision in the bill will require a principal place of residence, a fixed principal place of residence, not the trunk of a car.

Medigap sales are made in the home; these agents become very friendly with their victims. They even take them to the bank when they need to transfer funds to pay the premiums. As older peoples' lives narrow down, they have less and less contact with the outside world and they trust a very small pool of people, one of whom can be an agent. That's the population that I think Jeff and I both are concerned about, reaching that population who can't come to senior centers and to public education forums.

The **Chairman**. We have some more displays around the room that indicate that the rural areas of America—the implication is they are more vulnerable out there in the rural areas. Is there any reason for this? This is in training programs for potential agents.

Mr. **Spitzer-Resnick**. I think the main reason for it—I also supplied the committee with a letter from another benefit specialist, the top heading is "Green County Human Services." The capital, Monroe, of Green County has a population of about 3,000 so it is a very rural area.

Ms. Flannery, the benefit specialist, sees this all the time and I think the reason for it is, as isolated as seniors are generally that problem is multiplied I don't know how many hundred times in the rural areas.

You literally have people who may live miles from another soul and never leave their home.

Ms. **Burns**. I have learned never to underestimate the creativity of the insurance agent when there is a premium to be collected. They will go any distance to get that premium.

The **Chairman**. I have been reading this brochure that I believe you submitted this to us, Your Key to Professional Selling, A&H Product Training Manual. It is really pretty awesome, the so-called methods and I guess you would say tricks that they employ.

Congress repealed Catastrophic Insurance in November 1989, I believe. How much has the average policy gone up since that time? This is dated 1990. I assume these costs have gone up since then?

Mr. **Spitzer-Resnick**. Those are 1990 figures. If I made a mistake, I apologize. I didn't indicate the increases. The increases have varied. I would say if you are looking at that chart, there is, believe it or not, one policy on there, and I am not going to say which one it was because I can't remember for sure, that did not rise.

The other policies in general raised approximately 15 percent. One of the policies raised close to 30 percent. In response to one of the Senator's questions earlier about what would it cost to buy a replacement for the Catastrophic benefits, you can't buy it. You can't get a policy that covers, for example, mammograms. It just doesn't exist.

Very few policies might cover the prescription benefits that Catastrophic offered. None of those costs include prescription benefits and those would be highly prohibitive in terms of expense. I would guesstimate that you would add another $300 per year in premiums just to get prescription coverage.

Ms. **Burns**. I'd agree with that. California does not have rate-setting regulation which means that they can do pretty much whatever they want with rates and they do.

What we have seen trickling through seems to be settling out in about the 22 percent range as far as increases are concerned.

The **Chairman**. Any further comments from this panel?

Ms. **Frost**. In regard to the rate increases, we did have a problem with a local HMO where they tried to go back and retroactively increase their rates against our State regulations in light of the repeal of Catastrophic.

In one instance, I assisted a lady and her policy wasn't expiring and needing to be renewed until April, but at the time she paid her April premium, she was retroactively going to be charged the increased premium back to January 1st which we reported to the Office of the Insurance Commissioner. It has since been remedied.

The **Chairman**. What happens in this kind of situation? Say a salesman walks in and I'm 70 years old and I buy a policy. I give him a check for $1300 to cover me for a year and then a month later, I die. What happens to that coverage at that time? The estate of the deceased does not get any kind of a rebate, is that right?

Ms. **Burns**. If you ask for it or demand it, sometimes you can recover it. If you threaten them with legal action, then very often you will get it back. Most cases such as you described would just go into the black hole. Unless somebody knew that had happened and went after the money, they'd never get it.

Mr. **Spitzer-Resnick**. I would concur with Bonnie's statement. The only thing I'd like to add is that unfortunately, one of the things I know Vickie does rather unfortunately too regularly is file complaints with our insurance commissioner. We get all too little action out of our insurance commissioner.

I would like to emphasize that Wisconsin, at least in talking with other advocates around the country, is looked upon as one of the better States in the country. In concurring with Bonnie, I shudder to think if Wisconsin is one of the best, what is it like around the rest of the country.

The examples you heard earlier from the two elderly witnesses and our prisoner on the video, those are not abnormal. The only thing that was abnormal about the elderly witnesses is that they were brave enough to come here.

Most older people, when they realize they have been had, are embarrassed and they feel bad. In fact, you heard one of the witnesses say that she felt somewhat naive about it. I think you were quite right in saying that none of us are up to snuff on all this stuff.

In trying to prosecute a case, or follow up on a complaint, it is very, very difficult.

Ms. BURNS. In the Chernecki case that I cited, they dropped out two of the victims from the case, one because the person died and the second because the victim was unwilling to get on the stand and say three years ago, these are exactly the words that this gentleman said to me and there is no doubt in my mind that's what he said. She was unwilling to do that and the department dropped her from the case, leaving only one or two victims left in that case.

In my experience, getting a senior to agree to file a complaint with the Department of Insurance is very difficult. For every one that I file, I would be willing to guess that there are 25 out there.

The CHAIRMAN. I want to thank the three of you today. This has been very helpful to this committee.

We are going to call our final witness. We have had a lot of discussion today about the insurance industry in this room and now we are going to hear from a portion of the insurance industry, Mr. Thomas Sick, Vice President, Physicians Mutual Insurance Company, Omaha, Nebraska, accompanied by Linda Jenckes of the Health Insurance Association of America.

We appreciate very much you coming, Thomas and Linda. We are proud that you are here with us today. You may proceed, Thomas, if you like.

STATEMENT OF THOMAS A. SICK, VICE PRESIDENT, PHYSICIANS MUTUAL INSURANCE COMPANY, OMAHA, NE, ACCOMPANIED BY LINDA JENCKES, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. SICK. Thank you, Mr. Chairman.

Mr. Chairman, I am Thomas Sick, Vice President of Physicians Mutual Insurance Company of Omaha, Nebraska. I am appearing today on behalf of the Health Insurance Association of America, the principal trade association of the commercial insurance industry. With me is Linda Jenckes, Vice President of Federal Affairs for HIAA.

I am submitting testimony for the record addressing confusion in the Medicare supplement market and proposals for improving that situation in ways that will enable prospective purchasers of private insurance to more readily make informed choices that best serve their economic interests and curb the occasional marketing abuses that are still being reported some ten years after the enactment of the Baucus Amendment reforms.

Medicare is a complex benefit program and it is important that any private health insurance designed to supplement does not further complicate it. Considering the changes the Medicare program has undergone in the last several years, it would appear that it is as difficult to understand now as it ever has been, which makes this an opportune time to make Medicare and Medicare supplement insurance as easily understood as we can.

A great deal has already been done to help seniors both understand Medicare and Medicare supplement insurance. Whenever a person eligible for Medicare applies to purchase any type of health insurance, they must be given a Government-written Guide to Health Insurance for People with Medicare booklet.

Also, at the time application for a Medicare supplement policy is made, the applicant must be given an outline of coverage that shows what is required under the minimum standards for such policies and which of those benefits are additional to the minimal requirements.

This information is provided to all applicants before a policy is issued to them and each applicant has a 30-day period following issue within which to cancel the coverage at no cost to themselves.

As you know, the States are in the process of implementing new NAIC consumer protection revisions to their Medicare supplement regulations. Generally, we in the industry have high hopes that these added protections will significantly improve private health insurance for senior citizens.

We suggest that before it acts to impose further changes, Congress should wait until it can evaluate the effects that the new NAIC provisions have on the marketplace.

We would like to state our support for S. 2189, the proposed Health Insurance Counseling and Assistance Act of 1990.

Simply put, we believe that many seniors would benefit from either group or one-on-one counseling concerning Medicare, Medicare supplement insurance and other forms of health insurance coverage as provided for in this proposal.

We note that plans for statewide programs under this legislation would need to assure that providers of counseling and assistance are conflict of interest free. We further suggest that in order to assure unbiased assistance to consumers that the legislation should prohibit all counselors from recommending specific policies or companies from which to obtain them.

With respect to S. 2050, Senator Kohl's bill, we believe the establishment of toll free hotlines in each State to assist callers with Medicare supplement questions or problems would be a worthwhile and cost effective initiative.

Regarding S. 2050's other provisions, we suggest that the more important question for consideration by the Congress is how actively and effectively current and new laws are being enforced.

The bill would also require all States prohibit premium increases for Medicare supplement insurance without the prior approval of State regulators. Virtually all States presently have such a requirement for individual policies but many do not require prior approval of group premium rates.

Finally, S. 2050 would raise the minimum loss ratio for individual Medicare supplement policies from 60 to 70 percent and require strict enforcement of the percentage requirements. We suggest the Congress should require strict enforcement of the current minimum loss ratio standards for Medicare supplement policies as set forth in the NAIC model regulation.

The new NAIC loss ratio standards now require that Medicare supplement policies meet actual, not just expected, standards. It is our understanding that most, if not all, States have authority now to order insurance not meeting the minimum standard to lower their premiums in order to do so.

However, raising the loss ratio standard for individual policies may have untoward effects that need to be carefully examined.

Mr. Chairman, we are pleased to have the opportunity to appear before your committee today. A better informed Medicare beneficiary is the key for better performance of the entire system.

If you have any questions, I would be glad to respond now or if necessary, submit information to you for the written record.

[The prepared statement of Mr. Sick follows:]

TESTIMONY
OF THE
HEALTH INSURANCE ASSOCIATION OF AMERICA

ON
MEDICARE SUPPLEMENTAL INSURANCE

PRESENTED BY
THOMAS A. SICK, VICE PRESIDENT
PHYSICIANS MUTUAL INSURANCE COMPANY

Mr. Chairman and members of the Committee, I am Thomas A. Sick, Vice President of the Physicians Mutual Insurance Company of Omaha, Nebraska. My company is licensed in all states and the District of Columbia and is a major underwriter of Medicare supplement insurance. I am appearing today on behalf of the Health Insurance Association of America, the principal trade association of the commercial health insurance industry. I am accompanied by Linda Jenckes, Vice President of Federal Affairs for the HIAA. The 330 HIAA member companies write over 85 percent of the private health insurance available from commercial companies in this country. Sixty HIAA member companies underwrite Medicare supplement policies and ten of those companies write the majority of that business.

I am here today in response to your request for our views on "confusion in the Medicare supplement market" and proposals for improving that situation in ways that will 1) enable prospective purchasers of private insurance to supplement Medicare to more readily make choices that best serve their economic interests and, 2) curb the occasional marketing abuses that are still being reported some ten years after enactment of the Baucus Amendment reforms.

At your request, we will also comment on the important new consumer protection provisions contained in the latest National Association of Insurance Commissioners model Medicare supplement regulation. These changes will be implemented by the states during the next year, in accordance with the terms of the Medicare Catastrophic Coverage Repeal Act of 1989.

Medicare and Medicare Supplements Are Complex

At the outset, it is important to note that Medicare is an extremely complicated benefit program - one whose details have been modified over the years by Congress. Beneficiaries may understand basic facts such as the amount of the current Part A hospital deductible ($592) or the fact that the program pays only 80 percent of Medicare-approved physician charges, leaving the beneficiary to cover the other 20 percent plus whatever additional amount above the approved level the physician may charge in nonassigned claims. But the circumstances under which various types of health services will or will not be covered by Medicare can be complex. Because most Medicare supplement benefits dovetail with those provided under Medicare itself, they reflect that complexity.

Nevertheless, a great deal has already been done to help seniors understand both Medicare and Medicare supplement insurance. Whenever a person eligible for Medicare applies to purchase any type of health insurance they must be given a 39 page government written "Guide to Health Insurance for People with Medicare" which contains a good basic discussion of Medicare, Medicare supplements and other types of private health insurance, and gives sound advice on shopping for coverage. Also, at the time application for a Medicare supplement policy is made, the applicant must be given an outline of coverage in a format prescribed by the government that shows 1) what Medicare pays and does not pay, and 2) which of the supplemental benefits provided by the policy are required under the minimum standards for such policies and which of those benefits are additional to the minimum requirements. Further, whenever Medicare changes its benefits, insurers are required to notify their supplement policyholders 30 days before those changes take effect, describing the changes in Medicare and any changes in their supplement coverage that will result from them.

Mr. Chairman, at this point, I would like to offer a copy of the current buyers guide and the model outline of coverage for insertion in the hearing record. I would like to emphasize, also, that this information is provided to all applicants before a policy is issued to them and that each applicant has a 30 day period following issuance within which to cancel the coverage at no cost to themselves.

New Consumer Protection Provisions

Earlier, I mentioned that states are in the process of implementing revisions to their Medicare supplement regulations. Under these new consumer protection provisions:

- Individuals purchasing Medicare supplement insurance policies cannot be cancelled for any reason except for failure to pay the premiums or a material misrepresentation.
- People obtaining coverage in group Medicare insurance policies are no longer subject to loss of coverage if their membership in that group ceases or the group policy itself terminates. They will be offered continuation of coverage through an individual policy.
- The number of Medicare supplement insurance policies that an individual may purchase or all agents and companies may sell to an individual has been limited, in effect, to one.
- In order to assure that sales of duplicative Medicare supplement policies do not occur, insurance companies are required, annually, to review their records for persons who have more than one Medicare supplement policy and report their findings to the states.
- While replacement of existing Medicare supplement insurance coverage with a new policy of that type will still be a choice allowed consumers, existing state requirements involving extensive disclosure of the results of replacement are supplemented by new requirements which:

-- Prohibit the new insurer from imposing any new preexisting condition limitations or waiting periods for similar benefits in the new policy, and

-- Place limits on compensation of agents in order to lessen their incentive to replace existing adequate policies.

- o Insurance companies and agents, when soliciting applications for Medicare supplement insurance policies, are required to obtain additional information concerning applicants' past and present health insurance coverage. This information will ensure that individuals do not own more than one Medicare supplement policy.

- o If they have not already done so, insurers are required to establish written marketing procedures to assure regulators that both existing and new consumer protection requirements are complied with.

- o Such practices as twisting, cold lead advertising, and high pressure tactics are specifically defined and prohibited as part of the sale of Medicare supplement insurance policies.

Importantly, these new consumer protection provisions are in addition to existing state regulations which

- o prescribe the minimum benefits that a Medicare supplement must provide,

- o require that policies automatically adjust to changes in Medicare deductibles and copayments,

- o specify the information that must be provided by an insurer or agent when a policy is sold or updated,

- o prohibit certain types of policy limitations or exclusions, and

- require insurers to meet loss-ratio standards involving the ratio of claim payments to premiums.

In addition to its broad authority to regulate insurance, virtually every state has in effect the Unfair Method of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance statute. While the text of the Unfair Trade Practices Act is lengthy, it addresses virtually every aspect of company and agent activity and prohibits practices such as providing false information or advertising, rebates, unfair discrimination, unfair claim settlement practices and other unfair methods of competition or deceptive acts or practices. Insurance departments have other sanction authority such as the agent licensing laws which also enable the state to issue fines, revoke licenses and publicize the results of disciplinary actions.

We can well understand that in the wake of the repeal of the Medicare Catastrophic Health Insurance Act, the Congress is especially interested in Medicare supplement insurance and is considering legislation aimed at correcting perceived marketing abuses and assuring that seniors receive fair value for their insurance dollars. However, we believe that the consumer protection provisions, now being put into place by the states, are more than adequate in most respects and suggest that, before it acts to impose further changes, Congress should wait until it can evaluate the effects that the new NAIC provisions have on the marketplace.

Health Insurance Counseling and Assistance Act

Having sounded that cautionary note, we would like to state our support for S. 2189, the proposed Health Insurance Counseling and Assistance Act of 1990. Simply put, we believe that many seniors would benefit from either group or one-on-one counseling concerning Medicare, Medicare supplement insurance, long-term care insurance, Medicaid and other forms of health coverage as provided for in this proposal. The dissemination of written material on these topics can only accomplish so much. We have no doubt that unbiased personal assistance would be a great help to Medicare beneficiaries seeking to choose health coverage that is appropriate to their circumstances. Programs of this type already in existence have earned a high degree of consumer support and their value has been recognized by a recent resolution of the National Association of Insurance Commissioners encouraging all states to develop them.

We note that plans for state-wide programs under this legislation would need to assure that providers of counseling and assistance are conflict-of-interest free. We would hope that this would not be construed to preclude retired insurance agents or retirees from insurance companies, Blue Cross and Blue Shield Plans or HMOs from participating. The expertise such individuals have acquired during their careers would be a considerable resource for counseling programs to draw upon, provided, of course, that they do not stand to make any special financial gain from their participation. Further, in order to assure unbiased assistance to consumers, we believe that the legislation should prohibit all counselors from recommending specific policies or companies from which to obtain them.

The national associations representing insurers, HMOs, Blue Cross and Blue Shield Plans and PPOs are useful resources from which the Department of Health and Human Services can obtain advice and information as it performs the responsibilities assigned to it under this proposal.

We also believe that the outreach called for by the proposal is very important, as many of the instances of seniors purchasing more insurance than they need involve persons living in isolated, often rural, circumstances. Outreach is also important in reaching persons on Medicaid who do not need to purchase a Medicare supplement or keep one they have already purchased because Medicaid will pay the Medicare deductibles and copayments.

Medigap Fraud and Abuse Prevention Act

Similarly, the establishment of toll-free hotlines in each state to assist callers with Medicare supplement questions or problems, as called for in S. 2050, Senator Kohl's bill, would be a worthwhile and cost-effective initiative.

Education Brochure: That proposal also calls for each state to develop a Medicare supplement policy educational brochure for distribution to applicants. We believe that the mandatory buyer's guide, which was prepared jointly by the federal Health Care Financing Administration and the National Association of Insurance Commissioners, together with the outline of coverage provided to each applicant for a supplement policy currently meet that objective.

Increased Civil Penalties: S. 2050 would increase the federal civil penalties for violations of the prohibited practices set forth in Section 1882(d) of the Social Security Act. Increasing the penalty from $5,000 to $25,000 for each infraction would indicate how seriously the Congress views such abuses. But we believe that penalties, in and of themselves, are not a particularly effective deterrent. It is the certainty of being caught and punished, rather than the severity of punishment that may be imposed, that deters people from engaging in prohibited activities. Thus, we suggest that the more important question for consideration by the Congress is how actively and effectively both federal and state laws are being enforced rather than whether the existing authorities and penalties are adequate.

We believe that both the federal and state governments already-possess adequate powers to deal with the relatively few abuses that occur. Agents and companies who-commit abuses in marketing health insurance to Medicare beneficiaries should be disciplined and the news media should be asked to cooperate in letting the public know who the bad actors are. The light of adverse publicity focused on the few who are misbehaving is the best way to achieve improvement.

Increasing efforts under existing law to expose and embarrass the bad actors will accomplish far more than additional regulations inadequately enforced.

The counseling program in Chairman Pryor's proposal and the hotline envisaged in Senator Kohl's bill could also be powerful vehicles for warning prospective purchasers about specific agents or companies that violate the law.

Duplicative policies: Senator Kohl would change Section 1882(d)(3)(A) of the Social Security Act so as to prohibit "policies which duplicate other benefits to which an individual is entitled rather than policies which "substantially duplicate" such benefits. Apparently, the adverb "substantially" is seen as an obstacle to enforcement because it renders imprecise the meaning of "duplicate". Our understanding is that "substantially" was written into the law in order to prevent severe penalties being imposed for de minimus, unintentional violations. Perhaps other language could be agreed upon that would offer this protection without being seen as an obstacle.

Prior Approval of Premium Rates: The bill would also require all states to prohibit premium increases for Medicare supplement insurance without the prior approval of state regulators. Virtually all states presently have such a requirement for individual policies, but many do not require prior approval of group premium rates. We suggest that before Congress imposes a prior approval requirement on states that have chosen not to follow that regulatory course, it should first find out whether there are any meaningful differences in the cost of Medicare supplement insurance between states that have prior approval and those that do not.

Minimum Loss Ratios: S. 2050 would raise the minimum loss ratio for individual Medicare supplement policies from 60 to 70 percent and require strict enforcement of the percentage requirements.

We certainly have no objection to strict enforcement of the minimum loss ratio standards for Medicare supplement policies as set forth in the NAIC model regulations. The new NAIC loss-ration standards now require that Medicare supplement policies meet actual and not just expected standards. It is our understanding that most, if not all, states have authority now to order insurers not meeting the minimum standard to lower their premiums in order to do so. However, raising the standard for individual policies may have untoward effects that need to be carefully examined.

Loss ratios are used primarily by the states to determine whether policy premiums are inadequate or excessive. Premiums are designed to account for the expected cost of covered services in addition to reasonable administrative expense, taxes and profit. Loss ratios are not a measure of investment return. Administrative costs vary by company and by the methods a company uses to market policies.

Companies market their policies in a variety of ways, through association groups, by mail, and through insurance agents. Where agents are used, the cost of compensating them is included in the price of policies. Because the cost of marketing and servicing group policies is lower than for individual policies, the states require a higher loss ratio for group than for individual business. Where employer association groups are used, the sponsor bares the cost of administration outside of the insurance program, and additional savings for groups are garnered through mass enrollment, limited group eligibility, and in some cases, nonprofit postage rates.

Because licensed agents help bring health insurance to millions of individuals young and old, their important role should not be misunderstood or underestimated. Agents can perform all of the following services for the elderly: explain Medicare's benefits, describe how policies will pay benefits, hand deliver policies, review options, answer questions, assist in claims filings, and help schedule medical Provider Review Organization reviews.

About a third of those seniors with private coverage in addition to Medicare have it provided by a former employer. Of those persons who have private coverage not obtained through a former employer, 45.1 percent purchased it through a group or association, 44.5 percent from insurance company or agent, 6.9 percent by mail, and 3.5 percent belong to an HMO.

The fact that approximately 5 million seniors turn to agents for advice on their health insurance needs is testimony to the value of the service they offer. We believe that compensating agents for the role they play in creating access to insurance is an eminently worthwhile expense appropriately reflected in the cost of many Medicare supplement policies.

Most important, it is agents that effectively reach individuals who are not reached by Blue Cross and Blue Shield plans (who tend to make coverage available but not actively market it) or organizations such as the AARP who market by mail.

For the individual consumer, loss ratios alone are not a sufficient measure of policy value. Excessively high loss ratios may raise questions of company solvency or inter-product subsidy. Loss ratios do provide some indication of the potential service aspects of policy coverage. What is important to consumers is that their policies perform as promised. Recent surveys by HIAA and AARP noted 90 to 95 percent consumer satisfaction with Medicare supplement policy claim handling.

We strongly urge the Congress to carefully consider all the possible ramifications of raising the minimum loss ratio requirement for individual policies before making a decision to take that step.

Mr. Chairman, we are pleased to have had the opportunity to appear before your subcommittee today. We know that you recognize the value of Medicare supplemental insurance in helping the elderly meet the substantial health care expenses that Medicare does not reimburse. We share your interest in seeing that supplemental policies continue to offer fairly priced, ethically marketed protection, and that our policyholders are satisfied with their coverage.

If you have questions, I will be glad to respond now or, where it might be necessary, submit information for the hearing record. Thank you.

The CHAIRMAN. Mr. Sick, the U.S. Senate has an Ethics Committee. I hate to say it, but I am a member of it. I have been on there 9 years and I have tried to get off but they won't let me off. We sort of, I guess you would say, monitor and police our own colleagues by using rules of the Senate. The House has separate rules.

The military has military tribunals to basically police their military officers and enlisted people. The physicians of this country have a system and a process by which they sort of police physicians. The lawyers have ethics standards through the American Bar Association and each of the State bars, they try, at least in some cases, to police. I am not sure they do a very good job.

What does the insurance industry have to police agents, monitor agents?

Mr. SICK. The history of the insurance industry in the type of self-policing you are mentioning has been to work as closely as possible with the NAIC, the National Association of Insurance Commissioners, in developing industry standards.

The industry itself is a very multifaceted industry. If you're thinking in terms of the casualty industry, the life insurance industry, the health insurance, these are widely disparate pursuits.

On the life side, you have standards of the National Association of Life Underwriters for their agency distribution side. Plus, you have standards for chartered life underwriters.

On the casualty side, you have the AIA which is a——

The CHAIRMAN. Does self-policing go on in these respective arms of the industry?

Mr. SICK. It is there, but it is not the dominant thing that you are looking for. I see what you are getting at. The industry could do a much better job in self-policing.

The CHAIRMAN. Do you think there ought to be more State or more Federal control of these insurance agents that we have heard about today and the representations they make to our senior citizens, and to all of us? Should the State or the Federal Government move in with more controls?

Just like Senator Simpson says, we have been listening to this for about 10 years.

Mr. SICK. I agree.

The CHAIRMAN. I don't know how much longer we are going to put up with it. We are going to do something. This Government does not operate—we don't usually do anything except respond. We are a responsive system, we are defensive basically.

When we take the offense is when we have our back against the wall. We will eventually have to do that with the budget crisis. We are defensive basically.

Either the Federal Government or the State government is going to do something. Which one?

Mr. SICK. My recommendation would be the State, primarily. For instance, the gentleman on the video tape this morning; there is no one in the industry that would defend that man, whether he be selling insurance, used cars or whatever. His actions were unconscionable. He is an embarrassment to every one of us in the industry.

Companies take great pains to see that their name doesn't appear on a chart of this nature, to see that it was not their agent appearing on that video tape. But, we are not flawless. Occasionally one will get through. Occasionally we will be misunderstood in making a presentation or creating a product. However, it is not to the company's benefit to do that.

The **Chairman**. If an Arkansas insurance agent say had several complaints filed against him or her and he said, well, it's gotten a little too hot here, we'll move down to Texas and get out of the State of Arkansas.

They move to Texas and go to work for X-company. Is there any system today that is in force that looks at that agent's background? Is there a national registry say that is on a national basis where that agent would have a certain number that would be a national number that would flash up on the screen with all the complaints against that person?

Mr. **Sick**. I wish you had asked this to Commissioner Taylor——

The **Chairman**. I will ask him to come back up here. Ron, would you come back? We are trying to find facts here.

Mr. **Taylor**. We do have a system, Senator, a database system that is tied in nationwide. I will be the first to admit that there are some flaws in that system. It is only as good as the reporting data.

The **Chairman**. I don't see why that would be a hard system with all the computerization we have today, I don't know why that would be a tough system to put together, Ron.

Mr. **Taylor**. I totally agree with you. We frequently find that Arkansas has reported more violations and actions sanctions than some of the much larger States and we know that can't possibly be right.

The **Chairman**. They move on to Texas or move on to Oklahoma or somewhere like that and do their thing again in those States as they have done here. I can't imagine why the National Association wouldn't have some sort of cross-checking mechanism here.

Mr. **Taylor**. I totally agree with you and I will carry that message back to the leadership of our organization and see if we can't enhance our efforts there.

The **Chairman**. Our friend, Mr. Sick, has just said he thinks the States ought to move in there and do more rather than the federal. What is your response, Ron? Do you think the States should be doing more and if so, what should you do?

Mr. **Taylor**. I certainly think that there should be more done. I think under the current framework we have the appropriate place for it to be done is in the individual States. There are some areas where we do need the assistance of the Federal Government or some Federal statutes to back us up in those efforts.

The **Chairman**. Just remember that our old Federal system up here in Washington, and I think this is no secret, we usually don't like to get into an issue unless we have to. We have more than we can say grace over, but we are going to get into this area unless the States do something and do it very quickly.

Mr. **Taylor**. I will certainly carry that message back and hopefully you can pass your proposal and that will assist us.

The **Chairman**. That will help a little bit. It is still not going to get to these people that work for Mr. Sick's company, and that work for Linda's industry out there. We've got to find those people and root them out of the system.

Senator Graham.

Senator **Graham**. My sense is that the Medigap industry is a very diffused, decentralized one. For instance, in Arkansas, what share of the Medigap market would the largest three or four companies have?

Mr. **Taylor**. The largest carrier probably writes between 40 and 45 percent of all the premium. That would be our Blue Cross plan which is a mutual insurance company, not a true hospital medical service corporation.

The largest three or four—let me state it this way. Probably the largest five or six carriers would have over 75 percent of the total premiums in the State.

Senator **Graham**. How many companies would write Medigap policies in Arkansas?

Mr. **Taylor**. I would say approximately 200 or 300.

Senator **Graham**. Why are there so many companies in this business?

Mr. **Taylor**. Excuse me, let me clarify that. There are probably 200 or 300 products out there. I would say there is probably about 130 or 140 companies.

Senator **Graham**. Why are there so many companies selling this product?

Mr. **Taylor**. I really can't answer that, Senator. I don't know.

Ms. **Jenckes**. Senator, maybe I can shed some light on this. I think we have to look at the type of products that are available. In questioning earlier, you indicated how many people get private coverage to supplement their Medicare benefits either pre-retirement or as part of their retirement packages. That is approximately 33 to 35 percent of the individuals.

So out of the 130 companies, some may not be actively marketing it but it's a conversion from employer provided group health benefits or a continuation of their pre-retirement benefits in which the employer continues to provide the benefits and just carves out those benefit provisions that they had pre-retirement that are now provided by Medicare.

It may look as though there are more companies actively marketing it than actually are.

If you take the breakdown from there, 45 percent of the products that are available, are available through a group or association. I would say probably the lion's share of that is through the American Association of Retired Persons.

Forty-four percent are sold through an individual company or agent; seven percent through the mail and approximately four percent are provided through health maintenance organizations.

The **Chairman**. What would that percentage be of agents?

Ms. **Jenckes**. Individual companies or through agents, 44 percent.

Senator **Graham**. I come back to my question. What are the fundamental economics that have created a circumstance in which there are over 100 companies in the State of Arkansas? I assume that this number would be proportionately typical of other States involved in this business.

That strikes me as being an unusually large number of companies who feel that they can make a profit selling this product which I would assume is fairly labor intensive in the sense of a lot of expenses in marketing, promoting, and managing these policies.

Mr. SICK. If I might address that, many of these companies are drawn into this in order to be competitive in the underage market. What I am saying is that if you intend to offer health insurance coverage to people say, for instance, who are age 55 now and they are looking for assurance that when they become eligible for Medicare, they will have access, you are almost obligated to have one of these in your portfolio with a guaranteed conversion for this individual.

I know companies that have been drawn into the market by this manner. Some are exclusively in the market.

Ms. JENCKES. I think the best illustration of that is out of all of the companies—we have about 320—there are only 60 in our membership that market the product and out of those, 10 companies really have the lion's share of the business.

Senator GRAHAM. That 10 having the lion's share of the business, has this been true for say 10 years or more or is this a new phenomenon?

Ms. JENCKES. No. I would say, Senator, that is relatively constant over the years since the inception of the Medicare program when Medicare supplemental insurance actually began to fill in the gaps the Medicare program itself was not providing.

Senator GRAHAM. I had asked the Commissioner earlier what were the costs of policies being sold in the post-Catastrophic health care era that provided the same benefits that Catastrophic would have provided.

Mr. Sick, in your company, what would your policy that has the same benefits that Catastrophic would have made available cost?

Mr. SICK. I can't give you the precise answer you're looking for, and the reason, as was pointed out earlier, in that I don't have a product that provides mammography benefits. I don't have a product that provides prescription drugs.

The difference between our product and the Catastrophic was approximately $7 a month coming in and going out.

Senator GRAHAM. You say the difference was $7?

Mr. SICK. Yes.

Senator GRAHAM. That means it was $7 more?

Mr. SICK. Both ways. When Catastrophic was implemented, it had about that much of an effect. When the Catastrophic was repealed, it had about that much of a reverse effect.

Senator GRAHAM. Catastrophic would have cost approximately $5 a month in the mandatory participation and then could have cost up to $800 in the initial year based on your income. I am trying to get a figure that would be comparable to that cost of Catastrophic as to what is available now in the private marketplace for similar benefits.

Mr. SICK. I am not sure that is possible. The reason I will say that is that there was a pre-funding mechanism for the prescription drug benefit in the Catastrophic where the funding device was put in place essentially a year before the benefit itself came online. That would almost throw everything out of tilt. I'm not sure you could get an honest comparison with that.

Ms. **Jenckes**. Senator, what I'd like to do is perhaps submit something for the record and just briefly describe at least what we feel the experience has been in that area.

Last year, the average premium cost—when you do averages, as several other witnesses said, it's most difficult because you have to take into account the regional differences in the cost of care, the age mix of that particular policy—but just as a rough description, I'd like to say that based on the premise that an individual last year did not have private insurance, they would have been subject to the $58.80 annual premium as a result of Catastrophic.

They also would have been subject to the $560 deductible. They also would have been subject to the $75 Part B deductible. That equals $693 before you take into account any surtax that would have been imposed.

I will presume just for the sake of description that there was no surtax, that this was a lower income individual, but this would not include any of the 20 percent co-pay for medical services that the individual would have been liable for.

Our average policies last year were in the range of $600 to $700, so in essence, I would say it could be a wash in terms of Government providing the benefit versus the private sector. In fact, I will even go beyond that and say if you include the surtax amount or the 20 percent co-payment amount the individual would have been liable for, they would have had a better buy in the private sector.

Senator **Graham**. I appreciate your further explanation and your willingness to supplement information. When you said last year, was that while Catastrophic was still in place or after the Catastrophic repeal?

Ms. **Jenckes**. This is while the first phase would have been into effect, that is why I took into account the fact the individual would have been liable for the Part A deductible. Most of our policies pay the Part A deductible.

They would also have been liable for the Catastrophic premium that was imposed on all beneficiaries regardless of income.

[Subsequent to the hearing, the following information was received:]

MEDICARE SUPPLEMENT PREMIUMS

It is important to look at the magnitude of premium increases being proposed by Medicare supplement insurers before examining the specific elements that led to premium increases. In a January 8 statement before the Special Committee on Aging, the General Accounting Office reported on a premium increase survey it had just done of 20 of the largest Medicare supplement insurers. The GAO found that the average 1990 increase was 19.5 percent. The GAO also reported that, generally, the companies attribute about half of the increase to the repeal of catastrophic, which resulted in certain minimum benefits being added back into policies, and the other half to other factors such as rising health care costs, utilization trends and operating costs.

I should mention that, unlike the Blue Cross and Blue Shield Association, the Health Insurance Association of America is comprised of competing companies, and, therefore, does not gather data on existing or proposed health insurance premiums of our members. If we were to do so, it might be found a violation of the antitrust laws aimed at price fixing. However, I can say that, based upon the limited information we have about current premium increases, we believe the GAO survey presents a fair picture of what is occurring. It agrees with our prediction - made to the House Committee on Aging prior to repeal of catastrophic - that average increases would be in the range of 20 to 25 percent.

An explanation of the specific factors which led to premium increases follows.

Repeal of the Medicare Catastrophic Coverage Act

Due to the repeal of Catastrophic, in 1990 all Medicare supplement policies, in addition to the other benefits they provide, must now cover the following expenses that they would not have covered had Catastrophic remained in effect. Specifically:

Part A (Hospital Services)

- $592 inpatient hospital deductible - the minimum benefit standard requires that Medicare supplements must either cover this entire amount or not cover it at all;

- $148 a day for the 61st-90th inpatient hospital days per benefit period;

- $296 a day for the 91st-150th inpatient hospital days (if the insured chooses to use nonrenewable Medicare lifetime reserve days);

- upon exhaustion of all Medicare hospital inpatient coverage, including lifetime reserve days, coverage of at least 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare up to a lifetime maximum benefit of an additional 365 days.

Part B (Physician Services)

- coverage of all coinsurance amounts (20 percent of Medicare approved charges) under Part B, regardless of hospital confinement, subject only to an annual deductible. (Had the catastrophic law remained in effect, the liability of beneficiaries and their Medicare supplement policies for copayments would have been limited to $1,370 in 1990.)

In addition to these benefit changes, the repeal also generated significant administrative costs for insurers because of the need to revise policies, file them for approval by state regulators and notify policyholders.

Many Medicare supplements provide broader coverage than the minimum required benefits. Optional benefits include out-of-hospital drugs, skilled nursing facility copayments, nursing home care not qualifying under Medicare, medical care outside of the U.S., and physician charges in excess of Medicare approved charge levels (balance billing). The costs of these optional benefits are also increasing. While the catastrophic program may have offset some of the cost of these benefits last year, their effect on premium must now be recalculated due to the repeal of the Catastrophic Act.

The Effect of Increasing Medical Costs on Medicare and Medicare Supplement Premiums

The majority of claims dollars paid out by Medicare supplemental insurers are for the 20 percent of Medicare-approved Part B charges which are the beneficiaries' responsibility to pay.

Due to rising physician fees, more services being provided the elderly, the higher cost of new technology and the fact many procedures which used to be done in hospitals are now done in doctors offices, Medicare Part B payments have grown from $13 billion in 1983 to $37 billion in 1989 - a compounded rate of 16 percent a year. It is estimated that the rate of increase will continue in 1990, resulting in payments by Medicare of about $43 billion for seniors covered under Part B.

Because Medicare supplement policies cover the beneficiaries 20 percent copayment, we are experiencing similar increases in supplemental claims payments.

The cost per claim is not the only problem, the number of claims is also rising. We believe that the increasing volume of Part B claims received by Medicare and supplement insurers is due in part to the "debundling" of services by providers.

Debundling, or increasing the volume of covered services per beneficiary, is one strategy some providers use to counter recent federal restrictions and cutbacks in provider payments.

We also note that incentives built into the Medicare prospective payment system, by encouraging a shift away from inpatient hospital treatment to outpatient procedures, have had the effect of increasing beneficiaries and supplemental insurers costs. Because outpatient procedures are covered primarily by Part B, at 80 percent of Medicare's allowable fee versus 100 percent when done on hospitalized patients, this means that Medicare supplement policies must reimburse 20 percent of an increasing number of outpatient claims.

While many factors have caused claims costs to increase, cost increases for Medicare supplemental policies closely parallel increasing Part B costs to Medicare. We believe that only drastic nationwide solutions can effectively cope with rising expenditures for physician services. The Medicare Physician Payment Reforms enacted as part of the Omnibus Budget Reconciliation Act of 1989 may be a major step toward a solution for Medicare supplements.

The **CHAIRMAN**. Senator Graham, thank you. Senator Kohl has returned. Senator Kohl has been presiding over the Senate. I hope you did a good job and kept our colleagues in order over there, Senator Kohl. Welcome back.

Senator **KOHL**. Thank you, Senator Pryor.

I didn't hear your testimony but I understood from some people who have been sitting here that you were discussing my piece of legislation and offered some comments. I would like to discuss with you some of the things you said.

You apparently were opposed to the increase from $5 to $25,000 civil penalty. What would be the source of your opposition to that or do I misunderstand?

Mr. **SICK**. In my written submission, I don't believe we opposed it. We suggested perhaps there were better ways to tighten the enforcement.

Senator **KOHL**. You are saying you are not in opposition to that but you are commenting, and I think I agree if you are, that is not certainly the only way in which or necessarily the most important way in which we improve enforcement?

Mr. **SICK**. Yes.

Senator **KOHL**. I would agree with that.

Mr. **SICK**. Aside from your proposed legislation, you made a comment earlier in the hearing that I thought had much merit—two that have stuck in my mind—yours on the period of time in which a person can take all of their sales material to a professional and ask him is this what I want to buy. I think that has much merit.

I would like to point out to you that all private Medicare supplement policies incorporate what we call a 30-day free look. What I am getting at is that you could even make this applicable at the time the policy is issued because then the person has a month to even take their policy, plus all of their disclosure statements to a professional and seek their advice.

Senator **KOHL**. What I was trying to urge is that we institute a system that would make it almost mandatory but not quite for an elderly person to see a counselor before he or she signs up on a Medigap policy.

Just giving 30 days after to sign the policy to have it looked over—if they weren't inclined to do it before, why are they going to do it afterwards? They would only find out later on when something happens and they find out the policy wasn't very good, duplicative, too costly or whatever. Usually that's more than 30 days after they buy the policy.

Mr. **SICK**. I totally support that. As a member of the industry if these people do not understand what they are buying, they are not going to stay with you very long. It is an inherent element of health insurance you lose money the moment you sell a health insurance policy as a company.

If these people aren't going to stay with you, you will never recapture that, so it is not just a bad business practice, it doesn't make very good sense. You won't stay in business very long.

The other comment that was made this morning that was something new was Senator Warner's reference in folding this into a larger advisory ombudsman type approach wherein a person could receive advice not only on their individual health insurance but the alternative, such as HMOs and PPOs, even get advice on what exactly their employer retirement plan will and will not pay.

I think this is important because if we are just addressing the individual health insurance element, it is but a part of the whole scheme that these people must decide within.

Senator **Kohl**. Apparently you thought in my bill I talked about prior approval of rate increases. I just want to make it clear I call for approval of rate increases, not prior. I understand the difficulties associated with prior approval of rate increases.

Minimum loss ratios, I suggested increasing from 60 to 70 and I think your comment was let's do a better job of enforcement before we increase our loss ratios. I do not substantially disagree with what you are saying. We need to enforce 60 percent and then think about 70 percent. If that is your position, then I quite agree.

Thank you, Senator Pryor.

The **Chairman**. Thank you, Senator Kohl.

Ms. **Jenckes**. Mr. Chairman, if I may I'd like to submit a recent survey of ours for the record. It addresses exactly what is available today. I think one of the most important things is that we were very concerned about duplication of policies.

In our survey it indicates that 85 percent of Medicare beneficiaries only have one Medicare supplemental policy. In the remaining 15 percent, they have two or more. We think it is outrageous that anyone should have 13 or 14 policies and we are pleased that the NAIC recently in its December action will in essence ban the duplication of any Medicare supplemental policy.

I'd also add that 90 percent of the beneficiaries seem to be satisfied with their policies and their benefits; 70 percent were only satisfied with the cost. We agree with that. We all have to do something to get Medicare's cost under control.

The **Chairman**. Thank you. I wish I could bring everyone back who has testified 90 days from now and say, okay, what's gone on since March 7th. I will be monitoring very closely and all of us will be because this is a tremendous problem we have.

There are a group of people out there who are not being protected. We are going to try our best to do that. That is the purpose of this committee, to be advocates for that part of our society that basically is vulnerable and can't help themselves.

Whether it's the State getting in it more, the Federal Government getting in it more, I bet all of us get more in it because we are going to see more and more of these horror stories and more times when that elderly vulnerable individual is being taken advantage of.

We are going to do something and I am pleading with you for the cooperation of your organization and you as individuals of the 50 States and those insurance departments, I'm pleading with the industry, for some sort of self-policing mechanism. I cannot understand why there is not some national register to watch these people and have a great degree of control.

It's been a very informative hearing. I think I have learned more about Medigap than I wanted to know but it has been very, very informative to me. I want to thank my colleagues, we had almost 100 percent attendance of the committee.

Our committee will be adjourned. Thank you.

[Whereupon, at 12:24 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

Item 1

A GUIDE TO PURCHASING MEDIGAP AND LONG-TERM CARE INSURANCE

Draft Information Paper

EXPLANATION OF TERMS

Accident Only Policies.—A type of health insurance that provides coverage for death, dismemberment, or hospital and medical care due to an accident.

Allowed/Medicare Approved Charge.—A charge determined by the insurer to be the maximum amount paid to a participating physician.

Assignment.—A provision in a Medicare provider's plan that states that a provider who accepts assignment also agrees to accept the amount of reimbursement determined by Medicare as payment in full; the provider then collects from the patient only the applicable deductible and 20 percent coinsurance amounts.

Co-insurance/Co-payment.—A percentage or amount of health expense for which you are responsible under an insurance plan.

Confinement Period.—The period of time which long-term care policies require that you stay out of the hospital before you will have to go through a new waiting or deductible period.

Custodial Care.—Care that is primarily for meeting personal needs such as help in bathing, dressing, eating, or taking medicine. It can be provided by someone without professional medical skills or training but must be according to a doctor's orders. Custodial care does not involve skilled care services and/or intermediate health-related care.

Deductible.—Amount of covered expenses which you must pay before your insurance plan will pay its benefits.

Dread Disease Policy.—A policy which provides coverage for a serious specific disease or diseases (frequently cancer), in which benefits are usually tied to hospitalization (a flat fee is paid for each day of hospitalization).

Elimination Period.—Period of time before benefits will be paid. (See also waiting period.)

Guaranteed Renewable.—An insurance contract where the insurer agrees to continue insuring you for a certain time period, or for life, as long as you pay the premium.

Health Care Financing Administration (HCFA).—A Federal agency (part of the Department of Health and Human Services) which administers Medicare and Medicaid.

Health Maintenance Organizations (HMO's).—An organized health care delivery system which provides a wide range of comprehensive health care services to a voluntarily enrolled population in exchange for a fixed and prepaid periodic payment.

Health Underwriting.—The process by which an insurer determines whether or not and on what basis it will accept an application for insurance based on the medical history and physical condition of the applicant.

Home Health Care.—A wide variety of services provided in the home which include nursing, therapy, personal care, and home health aides/homemaker services.

Hospice Benefit Period.—Under Medicare, the period of time a qualified person may elect hospice care services in lieu of regular Medicare benefits. Persons who qualify for hospice care may elect three hospital periods of 90, 90, and 30 days for a total of 210 days of coverage.

Hospice Care.—A mode of care that emphasizes pain relief and comfort rather than curative care for patients for whom there is no chance of a cure. Such care is designed to help terminally ill patients remain free from pain and in the home or home-like environment as long as possible.

Hospital Indemnity Policy.—A policy which pays its benefits in cash on a daily basis when you are hospitalized.

Intermediate Care Facility.—Generally, health-related care provided in nursing homes that includes care provided by skilled nursing or rehabilitative professionals, as well as nonskilled care provided by para-professionals such as nurse aides.

Lifetime Reserve Days.—Under Medicare's Hospital Insurance Program (Part A), benefits for 60 additional hospital days which you can use over your lifetime if you have an illness and have to stay in the hospital for more than the 90 days covered in a benefit period.

Long-Term Care Insurance.—Insurance policies that may cover a range of medical, personal, and social services delivered over time to meet the needs of chronically ill or disabled persons.

Medicaid.—A Federal/State cooperatively funded and State operated program of health benefits to low-income persons.

Medicare.—A Federal health insurance program for persons aged 65 and over who are eligible for Social Security or Railroad Retirement benefits, and for some people who are under age 65 who are disabled, and meet Medicare's disability requirements.

Medigap.—Private health insurance designed to supplement Medicare by covering the gaps, and often some additional services, not paid for by Medicare.

National Association of Insurance Commissioners (NAIC).—A national organization of State executives representing State insurance commissions or departments that develops model legislation and regulations on insurance.

Participating Physician.—A physician who has agreed in advance to accept assignment on all Medicare claims for a 1-year period.

Pre-Existing Condition.—A physical and/or mental condition suffered by an insured individual that existed prior to the effective date of the policy. Insurance policies may limit benefit payments for pre-existing conditions.

Premium.—The amount that must be paid to purchase an insurance policy or keep it in effect.

Primary Care.—Basic or general health care—the patient's usual entry point into the medical care system.

Probationary Period.—A period from the policy's effective date to a specified time, usually 15–30 days later, during which no coverage is provided.

Skilled Nursing Facility Services or Care.—Generally skilled care and rehabilitation services provided to sick and injured persons by skilled personnel such as registered nurses or therapists.

Waiting Period.—Period of time that must pass (after the effective date of coverage) before the policy will provide benefits for a pre-existing condition or that must pass before benefits are provided.

Wavier of Premium.—Provision in a long-term care policy that allows the policyholder to stop paying the premium while in a nursing home.

INTRODUCTION

The Medicare Program was never intended to cover all the health care costs of the elderly and disabled population it serves. Yet, over the last decade medical costs and the gaps in Medicare coverage have grown far more than anyone could have anticipated. To fill these gaps, insurance companies have developed insurance policies (often termed Medigap) to supplement Medicare coverage, which an estimated 75 percent of the Nation's older Americans have purchased. In addition, 5 percent of the Nation's elderly have purchased long-term care policies. Unfortunately, purchasing Medicare supplemental and long-term care insurance can be a confusing and expensive challenge.

This guide is intended to make that job easier. It is not intended to be the final word on choosing private insurance. In its limited space, this guide should help answer some basic questions about how to fill the gaps in your Medicare coverage. For example:

- What does Medicare pay for?
- What doesn't Medicare cover?
- What do I need to do to close the gaps in Medicare coverage?
- How can I get the best Medicare supplemental coverage for my money?
- What options are available to me for protecting against long-term care costs?
- What are some of the common pitfalls I should avoid in choosing a Medigap policy and/or a long-term care policy?

THE MEDICARE PROGRAM

The Medicare Program is divided into two parts, referred to as Part A and Part B. Part A covers hospitalization costs, and Part B covers physician and surgeon charges in and out of the hospital, as well as other medical charges out of the hospital. (NOTE: The lower left hand side of your Medicare card will indicate the coverage you have, Part A or Part B, or both.)

PART A (HOSPITAL INSURANCE)

You receive Part A of Medicare automatically at age 65 if you are eligible for Social Security or if you qualify for disability benefits. If you are 65 and not automatically eligible for Social Security, you can obtain coverage by paying a monthly premium of $175 (1990 amount).

If you are hospitalized, Part A covers the charges customarily associated with a hospital bill, including charges for a semi-private room, meals, nursing services, a special care unit, operating and recovery rooms, medical supplies and appliances, rehabilitation services, and, if billed by the hospital, drugs, and laboratory and radiology services. In addition, Part A covers medically necessary in-patient care in a Medicare certified skilled nursing facility, or SNF, after a hospital stay of at least 3 days, as well as home health care (Medicare covers only medically necessary skilled care), and hospice care. For SNF care Medicare covers 100 percent for the first 20 days; from the 21st day through the 100th day, Medicare covers costs after a required co-insurance charge of $74 (1990 amount) a day.

You should remember that most nursing homes are not Medicare certified skilled nursing facilities. In addition, Medicare does not cover custodial care—the level of care most commonly needed by those with chronic illnesses.

Medicare measures the quantity of services it covers according to a *benefit period.* Medicare will pay for up to 90 days of hospitalization for each benefit period. The 90 days are renewable when you start another benefit period after a wait of 60 days. Medicare pays in full for the first 60 days of a hospital stay, except for a $592 (1990) deductible. From the 61st through the 90th day in a hospital during each benefit period, Part A coverage pays for all covered services except for $148 (1990) a day.

Medicare hospital insurance covers an additional 60 hospital days, referred to as "lifetime reserve days," if you have a long illness and have to stay in the hospital for more than 80 days. *Once you use a reserve day you never get it back.* Part A pays for all covered expenses except for $296 (1990) a day for each reserve day you use. Less than 2 percent of beneficiaries use even 1 day of these lifetime reserve days.

PART B (MEDICAL INSURANCE)

Part B coverage is obtained by paying a monthly premium of $28.60 (1990) which usually is deducted from your monthly Social Security check. It is important to remember that the premium is subject to change on an annual basis.

Part B coverage helps pay for doctors' services, outpatient hospital care, physical therapy, speech pathology services, and home health care. It also helps pay for a number of other benefits, including diagnostic tests, prosthetic devices, medical supplies, independent laboratory tests, certain ambulance services, radiology and pathology services, administration of drugs that you cannot administer yourself, limited chiropractic, podiatric, outpatient psychiatric care, and dental surgery.

After you have paid a $75 deductible, Part B will pay for 80 percent of the "allowed" or Medicare-approved charges for any additional covered services during the rest of the year. You are responsible for the remaining 20 percent plus any amount of the physician's charges in excess of the approved amount.

When seeking medical services, ask your doctor if he or she will accept Medicare "assignment." If your physician accepts assignment payments as a "participating" physician (a list of "participating" physicians should be available from your closest Social Security office or area agency on aging), it means he or she agrees to accept the fee "allowed" (i.e., covered) by the Medicare system. Your physician may also accept Medicare assignment on a case-by-case basis. Be sure to persist in finding this out. If your physician does not accept Medicare assignment, you may be charged the excess over the "allowed" charge, in addition to the 20 percent portion you must pay under the Medicare Program.

AN EXAMPLE

[Amounts in dollars]

	Actual charge	Medicare "allowed" charge	Out-of-pocket cost to beneficiary
Participating physician [1]	100	100	[2] 20
Nonparticipating physician [3]	200	100	[4] 120

[1] A participating physician will receive payment directly from Medicare.

[2] 20 percent of "allowed" charge.

[3] With a nonparticipating physician, you must front the cost and then follow-up with Medicare or your supplement insurer for reimbursement.

[4] 20 percent of "allowed" ($20) plus excess over "allowed" charge $100.

THE COVERAGE GAPS

A quick review of the Medicare Program reveals some obvious gaps in health coverage for the elderly. Clearly, a Medicare beneficiary is responsible for paying program deductibles and co-insurance. These can add up very quickly. Less obvious, but equally important, is the fact that Medicare does not cover the costs of custodial nursing home care, outpatient prescription drugs, or certain other forms of care.

THE HOSPITAL COVERAGE GAP

A serious illness resulting in a long hospital stay may involve sizable out-of-pocket expenses which you must pay, including:*

- $592 deductible;
- $148 a day co-payment charge for 30 days, beginning with the 61st to the 90th day of a hospital stay (a beneficiary would potentially be liable for a total of $4,440);
- $296 a day co-payment for each reserve day you might use plus total costs after reserve days run out (100 reserve days would amount to a maximum of $29,600); and
- $74 a day for days 21 through 100 of skilled nursing care only after a hospital stay of at least 3 days (days 21 through 100 would amount to a total of $5,826).

THE PHYSICIAN COVERAGE GAP

Gaps in physician coverage could result in thousands of dollars of costs not covered by Medicare.

If a physician does not accept assignment, possible uncovered costs include:*

- $75 deductible;
- 20 percent of all Medicare "approved" physician costs; and
- 100 percent of any excess charges above Medicare "approved" costs.

Other costs not usually covered by Medicare include those for:

- Routine examinations such as physicals, eye examinations (refractions), dental care, hearing, and podiatric care; and
- Routine eyeglasses, hearing aids, and dentures.

In addition, Medicare does not cover the cost for care provided outside of the United States (although limited exceptions for Mexico and Canada exist), or costs for services that are not determined to be medically necessary.

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*Figures are for 1990 only.

As you can see, a participant's exposure for large physician bills could be great. For example, a $10,000 doctor bill with $7,000 in "approved" charges could cost the participant up to $4,475 in out-of-pocket doctor bills ($75 deductible, $1,400 co-payment, $3,000 excess payment).

The Prescription Drug Gap

Although Medicare will cover the cost of drugs furnished during a hospital stay, it will not pay for any prescription drug costs after you leave the hospital or skilled nursing facility, and Medicare covers very few drugs provided on an outpatient basis (Medicare will cover certain forms of chemotherapy and nutrition therapy under very limited circumstances). Prescription drug costs have increased at a higher rate than other medical costs and represent, for most older Americans, their highest out-of-pocket costs.

The Nursing Home Care Gap

Medicare pays for only limited skilled nursing care in a nursing home through the SNF benefit. Most nursing home residents do not meet the stringent criteria necessary for the SNF benefit. In particular, custodial care (which includes assistance with activities of daily living such as bathing, dressing, and eating) is not covered under Medicare. Medicare does, however, cover assistance with activities of daily living when included as part of covered SNF care.

OPTIONS FOR FILLING IN MEDICARE'S GAPS

COVERING THE COSTS OUT OF YOUR OWN POCKET

Some older Americans may feel that they are able to cover all their health care expenses out of their own pockets. However, it is important to keep in mind that the cost of medical care has increased almost twice as fast as the costs of other goods and services in the last decade. Thus, personal resources that are adequate today may not suffice in the future.

CONTINUING A GROUP POLICY YOU JOINED PRIOR TO REACHING AGE 65

Many employers allow retirees to convert their group insurance to a Medicare supplement after retirement. In 1986, 68 percent of health plan participants in medium and large size firms were entitled to health coverage after retirement.

If that is the case with your former employer, examine the benefits and costs of your plan in comparison to other supplemental policies. If you switch to another supplemental policy, be sure to continue coverage under your old policy long enough to cover any waiting periods the new policy may have. (A waiting period is the time between the date when you become insured and the date when the policy will pay benefits for a pre-existing condition or certain specified illnesses.) Otherwise, you may not be protected for as much as 6 months.

Do not drop your policy without adequate advice. If the premium is paid by the employer, or even if a small amount is paid by you (the retiree), it is sometimes prudent to retain it and buy a minimum benefit supplemental policy for complete coverage.

RECEIVING HEALTH BENEFITS FROM THE WORKPLACE IF AGE 65 OR OVER

If you are employed and age 65 or over, or married to someone who is employed and age 65 or over, you may be protected by Federal law. Federal law requires that employers with 20 or more employees offer employees over age 65 and their dependents the same health insurance coverage offered to younger workers. Also, at age 65, a worker becomes eligible for Medicare, which pays its benefits after the employers's plan pays.

CHOOSING A SUPPLEMENTAL (MEDIGAP) POLICY

The purpose of a Medicare supplemental policy is to fill the gaps in Medicare coverage. Policies that are called Medicare supplements *cover services only after Medicare pays first.* These policies are sometimes referred to as Medigap policies. However, if Medicare denies payment for services, the Medicare supplement may not pay for those services. Older Americans generally need only one comprehensive Medicare supplement. Twenty-five percent of all insurance dollars spent by seniors is for unnecessary or overlapping coverage.

MEDICARE SUPPLEMENTAL POLICIES VARY IN TERMS OF COVERAGE

Medigap "thrifty models" provide the minimal coverage required by law: After exhausting all Medicare hospital inpatient benefits including the lifetime reserve days, this type of policy covers 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days; the Part A blood deductible; and the Part B 20 percent coinsurance.

Other Medigap models vary in terms of coverage paying anything from the Part A deductible to Part B expenses to coverage of prescription drugs. Make sure you do not pay for benefits you do not want or need.

CHOOSING A HEALTH MAINTENANCE ORGANIZATION

Health Maintenance Organizations (HMOs) are a relatively new option for Medicare beneficiaries. HMOs differ from health insurance and fee-for-service physician care in that they provide and finance health care. In an HMO, you pay a monthly or annual premium. In exchange for the fee, you will not be charged substantial additional costs for your medical care. A Medicare HMO may absorb the Medicare deductibles or co-insurance, and provide additional benefits. A Medicare HMO can provide you with all Medicare-approved services.

To be eligible for an HMO, you must be enrolled in Medicare's Part B. Also, you must either have Part A of Medicare or pay a higher monthly premium to the HMO. You also must live in the HMO's geographical area for at least 9 months of the year.

Medicare recipients cannot be denied enrollment to an HMO because of advanced age, or any "pre-existing medical condition," no matter how severe, with the exception of persons with end-stage renal disease or in a hospice benefit period. Medicare HMOs are required to have at least one 30-day open enrollment period every year.

HMOs provide all services that you receive under Medicare, as well as some additional services. For example, some HMOs cover inpatient hospitalization costs in full, including the Medicare deductible. Other services may include immunizations, prescription drugs at reduced cost, routine eye care, physical examinations, and others. The costs and benefits vary from plan to plan.

TIPS ABOUT PURCHASING SUPPLEMENTAL HEALTH INSURANCE

Here are some important factors to consider:

- Identify *Medicare's gaps* to determine what is important to you in a Medicare supplemental policy. Also consider such policy features as premiums, waiting periods, pre-existing condition exclusions, and maximum benefit clauses.
- *Take into account any other coverage you have* that continues beyond age 65.
- *Consider how much you can afford to pay* out of your own pocket for hospital or medical bills and how much you can afford to pay for supplemental health insurance premiums.
- *Find out which doctors accept Medicare assignment and are participating physicians.* Lists should be available at your nearest Social Security office or area agency on aging.
- *Work with hometown agents and companies that you know.* A company must meet certain qualifications to do business in your State. In most States, agents must also be licensed by the State and must carry proof of licensing showing their name and the company they represent. Ask whether they belong to any professional organization so you can check their credentials.
- *Talk with your friends* who have good claims experience with their Medigap policies.
- *Investigate group insurance sold by legitimate organizations and associations.* Some of the senior citizen or retired person organizations are "legitimate" and others are "gimmicks" set up as fronts to get your business. And while some of these plans are good deals, others are expensive and not as good as individual plans.
- *As a general rule, purchase one good comprehensive Medicare supplemental policy.* There are some exceptions if you have an employer group policy that is affordable, but limited in benefits. In this case, it may be advisable to have someone knowledgeable go over the options with you.

- *Check for special circumstances* for which the insurance company may eliminate coverage for a health condition you had before you bought the policy. A policy may refer to this as a "pre-exising condition."
- *Beware of replacing existing coverage.* Be suspicious of a suggestion that you give up any policy and buy a replacement. Replacement policies should meet the 1990 standards established by the National Association of Insurance Commissioners which prevent insurers replacing coverage from imposing any additional or new pre-existing condition, waiting, elimination, or probationary periods.
- *Check your right to renew.* Beware of policies that let the company refuse to renew your policy on an individual basis. Pursuant to 1990 standards established by the National Association of Insurance Commissioners, policies must be guaranteed renewable.
- *Remember, policies to supplement Medicare are neither sold nor serviced by State or Federal governments.* Do not be misled into assuming such policies are government-sponsored.
- *Don't pay cash for insurance.* Write a check or money order payable to the company, not the agent. However, you should not pay for the annual premium until you have received the policy; a deposit should suffice (e.g., 1 month's premium).
- *Keep the agent's and/or company's name(s), address(es), and telephone number(s).* In case of problems you should be able to contact them easily.
- *Take your time.* The Medigap insurance market is highly competitive with abundant products to choose from. Do not let a short-term enrollment period pressure you. Most legitimate policies will not have limited enrollment periods. Some States prohibit special enrollment periods.

KNOW YOUR RIGHTS

It is important to know your rights. *Any agent trying to sell you a Medigap policy that duplicates either your*

Medicare coverage or any private insurance you have may be subject to criminal penalties. Anyone pretending that he or she is from Medicare or any Government agency is also subject to such penalties. If you own Medicare supplemental policies with overlapping benefits or have ever had an agent tell you that he or she represented Medicare or a Government agency, notify your State Department of Insurance.

There are minimum standards that policies must meet to be labeled Medicare supplements. They apply only to policies issued after 1980 and they do *not* apply to other policies such as long-term care insurance, hospital indemnity policies, or dread disease policies. The minimum standards for Medicare supplement policies are:

—Pre-existing conditions may not be excluded after the policy has been in force for 6 months.

—Individual policies must pay out 60 or 65 percent (depending on the State) of all premiums collected as benefits to the purchasers of the policy. Group policies must pay out 75 percent on group coverage. (Employer furnished contracts are exempt from this.)

—Older consumers are entitled to a 30-day free-look period (from the date of delivery of the policy) during which time the policy may be returned and the premium refunded.

In addition, the policy you buy should meet the 1990 standards established by the National Association of Insurance Commissioners, which include:

—Coverage of either all or none of the Part A deductible;

—Coverage of Part A hospital co-insurance amounts;

—90 percent of hospital costs after Medicare hospital benefit is used up—not to exceed 365 days;

—Part A blood deductible; and

—Part B—20 percent co-insurance.

TIPS ABOUT HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

Here are some important factors to consider:

- ***The HMO handles the paperwork.* You don't have to file any claims.**

- *You must obtain all health care services through the HMO.* Selection of physicians and hospitals is limited to those contracting with or employed by the HMO. You will not be covered for services outside the HMO except under very limited circumstances. You choose your doctor from a list provided by the HMO. You can't see a specialist without approval from your "primary care physician" (internist or family doctor). However, emergency situations would be covered. Check to see if your doctor or hospital participates with the HMO. Your present doctor may also see HMO patients.
- *If you travel frequently, the HMO might not meet your health care needs.* Check individual programs carefully—some large HMOs offer "reciprocity" which allows you access to services in other cities and States. Most HMOs, however, will not cover you for travel with the exception of emergency situations.
- *When you are a member of an HMO, you have fewer out-of-pocket expenses.* In effect, HMO physicians "accept assignment" from Medicare as payment in full. In most HMO's, an office call is either free or has a small cost. Hospitalization is paid for completely.
- *In some cases your care may be given by nurse practitioners or others* under the supervision of the doctor.
- *If you are unhappy with your HMO doctor, you may choose another HMO doctor.* If you are dissatisfied with the HMO, you may leave it. However, you might not be able to join another HMO right away, because the "open enrollment" period could be over. You could wait up to 11 months to join another, but you would still get your standard Medicare coverage back if you left the HMO.
- *Monthly premium rates are guaranteed for 1 year only.*
- *Medicare HMO plans are meant to be inclusive health care plans to replace the need for supplemental insurance or Medigap policies.* Further, if you leave the HMO and then reapply for supplemental insurance, it could be difficult or expen-

sive to obtain a comprehensive policy if you have a serious "pre-existing medical condition."

- *Like other Medigap supplements, the HMO doesn't cover every possible health problem.* For example, most plans do not cover long-term care except for the few short-term acute nursing home care stays currently allowed under the Medicare Program. To date, dental care, eyeglasses, and hearing aids are not routinely covered. Therefore, it is important to compare benefit levels among plans.
- *If the HMO goes out of business, or if the HMO drops its Medicare plan, it must give you 60 days advance written notice.* In either case, you would still have your basic Medicare coverage. In addition, the HMO must provide you with coverage for any pre-existing condition for at least 6 months.

SHORT TERM INSURANCE FOR TRAVEL ABROAD

If you only travel abroad once in awhile, you may want to purchase a *short-term travel policy.* These policies are available through travel agents and can be adjusted to your needs. Unless you travel often, do not buy a Medicare supplement based on this option.

LIMITED POLICIES TO STAY AWAY FROM

There are several types of limited policies that may be advertised by celebrities and sound like wise choices. However, they are often not designed to fill in Medicare's gaps and are, frequently, a waste of premium dollars. These policies often duplicate coverage already included under Medicare and a comprehensive supplement policy. Thus it is probably more prudent to concentrate your premium dollars in the most comprehensive supplement policy that you can get. Limited policies include the following:

Hospital Indemnity Policies.—Indemnity policies, which are of limited value for most, pay a fixed amount each day, week, or month while you are in the hospital. They will pay you regardless of whether you have other hospital coverage. However, you cannot collect unless you are in the hospital. Hospital indemnity policies are probably not wise choices for filling in Medicare's gaps.

Accident Only Policies.—Accident only policies provide coverage for death, dismemberment, or hospital and medical care due to an accident. They are not designed to pay routine health care costs. These policies are of limited value for most.

Dread Disease Policies.—Dread disease policies cover you for specific diseases like cancer. These policies pay in few situations and a number of States have banned their sale.

MEDICAID AND VETERANS' BENEFITS

Medicaid pays for medical and nursing home care for certain categories of people who have limited income and assets. If you are a Medicare recipient and cannot afford supplemental insurance, are not eligible for Medicare, or you are over 65 and have a low income, you should investigate the possibility of receiving Medicaid assistance. In many States, if you are eligible for Supplemental Security Income (SSI), you are also eligible for Medicaid. In order to find out if you are eligible for Medicaid, contact your closest State or county Department of Social Services. (You may be able to obtain information from your local area agency on aging.) If you already receive Medicaid assistance, supplemental insurance is not necessary.

Veterans' Benefits.—If you are eligible for veterans' benefits, you may receive more comprehensive coverage than you would under Medicare. For example, in addition to hospitalization, veterans with service-related disability *may* qualify for treatment in a VA or private nursing home. Eligible veterans may have to wait for an available bed to receive treatment, however. To apply for veterans' benefits, contact your closest Department of Veterans Affairs office.

NURSING HOME AND HOME CARE LONG-TERM CARE POLICIES

Gains in life expectancy in this century have resulted in a greater number of persons living to advanced ages, and as a consequence, these people are more likely to suffer from various chronic conditions, or to experience declines in their ability to function independently.

Long-term care is the wide range of medical and support services that may be available for people who, as a result of these conditions, need help in caring for themselves over long periods of time, often for as long as the person receiving the service lives. Individuals in need of such care may require part- or full-time help. The help may range from high-technology services for those dependent upon ventilators to low-technology services such as cooking or shopping. Although many assume that most long-term care takes place in nursing homes, the truth is that the majority of long-term care services are provided in the home by family members.

PROTECTING AGAINST THE COST OF LONG-TERM CARE

More than half of nursing home costs are paid for by nursing home residents or their families.—Medicare pays for less than 2 percent of nursing home costs and Medicare supplement or long-term care insurance pays even less. Medicaid pays for nursing home care, and sometimes home-health care, for those who meet low-income requirements. Medicaid covers about 44 percent of all nursing home expenditures.

Facts to remember about long-term care:

—*Medicare does not pay for long-term care.* It does pay for skilled nursing facility and home health care benefits, but these must be medically related and are short-term in nature;

—Medicare supplemental plans do not pay for long-term care; and

—In order for Medicaid to pay for long-term care you must meet low-income requirements.

At present there are not many options for protecting against the costs of long-term care. Financing such care is an issue which is being examined by many, including Congress. A relatively new form of protection against long-term care costs that is receiving a great deal of attention is long-term care private insurance.

Long-Term Care Insurance is Not for Everyone.—Long-term care insurance has begun to be marketed by the insurance industry within the last few years. Typically, long-term care policies offer benefits for a limited range of services provided in a nursing home and, to a far lesser extent, at home. They have been very restrictive in providing benefits and typically are expensive. A recent study by the United Seniors Health Cooperative in Washington, D.C., reported that holders of nursing home policies in 1988 had a 2 in 5 chance of collecting coverage. However, as interest in these products has increased, policies are improving.

Careful consideration should be given to the purchase of long-term care insurance. Long-term insurance is not for everyone. Some advocates recommend that, in general, if a person's income is under $20,000 and assets and savings are under $30,000 (excluding a home), it may not be a good option.

Checking Out Policy Variables.—Very few long-term care policies cover everything. In addition, few policies provide care for indefinite periods of time. For most people, nursing home care is thought of as a last resort and they prefer, whenever possible, that long-term care should be provided at home.

TIPS ABOUT PURCHASING LONG-TERM CARE INSURANCE

The following are the options you will need to consider when purchasing a long-term care policy. It is also worthwhile to review the warnings on supplemental insurance in this publication; they apply to long-term care insurance as well.

- *Determine the level of care that the policy covers.* Level of care refers to the intensity of care and types of services needed by individuals. Distinctions in level of care also describe facilities and the care they can and do provide. Policy definitions for levels of care are usually not the same. Avoid policies which require that you first be admitted to a nursing home at a skilled level of care before the insurance company will pay for another level of care. Also, beware of policies which reduce the amount of benefit for lesser levels of care. Here are the three major recognized levels of care:

  Skilled Care is intended to return a patient to a former level of care. It includes *daily skilled nursing or rehabilitative inpatient services* which are administered by skilled personnel, such as a registered nurse, physical therapist, speech pathologist, or medical doctor. Care must be based on a doctor's orders.

Intermediate Care includes *occasional care* provided by skilled nursing or rehabilitative professionals. It also includes nonskilled care provided by paraprofessionals such as nurse aides. Care is based on a doctor's orders and is provided under the supervision of skilled medical personnel.

Custodial Care provides *personal assistance* in activities of daily living such as bathing, dressing, and giving oral medications. Such services can be performed by the average nonmedical person. Care can be based on a doctor's certification that such care is necessary.

- *Make sure that any policy that you consider provides inflation protection for the daily coverage rate.* (Inflation protection will ensure that the daily coverage rate automatically increases with each year for a certain number of years in order to keep up with inflation.) Daily policy rates are usually $20 to $100 a day. (At present, the average national cost of a nursing home is between $65 to $70 a day.)
- *Find out how long the policy will provide benefits.* Policies do vary. Keep in mind that for those who are admitted to a nursing home for a chronic condition and stay for more than 3 months, the average length of stay is 2.5 years.
- *Do not buy policies with a requirement for prior hospitalization.* Many policies have prior hospitalization requirements which means that you must be hospitalized first before the insurance company will cover nursing home costs. However, many people who enter nursing homes need custodial care without first needing hospitalization and it is not easy for a physician to "admit you in the hospital for a few days."
- *Make sure the policy covers the levels of care which you want to have covered.*
- *Avoid purchasing a long-term care policy with a period of confinement of more than 90 days.* Long-term care policies include requirements called *periods of confinement* or *period of care provisions* that tell you how long you must stay out of the hospital or nursing home before you will have to go through a new waiting or deductible period.
- *If you choose to purchase a policy with a waiting period, make sure you understand how much you will have to pay out-of-pocket before any coverage begins.*

Policies usually state that for a certain period of time from the effective date, such as 6 months or maybe 2 years, the policy will not cover you for any medical condition that you already had. This is called a waiting period for preexisting conditions. During a nursing home stay, you will have to pay all of the costs. Because of the costs, a waiting period longer than 6 months does not make sense for many people. Keep in mind that these policies are designed to be purchased in advance of need.

- *Closely review the cost implications of an elimination period.* This means that before the policy will pay benefits, you will have to cover all of the costs for a certain amount of days. The longer the elimination period, the less expensive the premium. Most policies will give you a choice of 0 to 120 days.
- *Make sure you are aware of what exclusions your policy contains.* Many people enter nursing homes because of disorders such as Parkinson's or Alzheimer's diseases. Some policies will not pay for care for these related disorders. There are many ways for a company to exclude such disorders by using confusing language.
- *Remember that most good policies do not require the policyholder to continue to pay premiums while you are in a nursing home.* (Typically, after 90 days of benefits the premiums are waived. This is often referred to as waiver of premium provisions.)
- Most policies are not sold to persons over a certain age, usually 80 or 85. (Premiums go up with increasing age.) *Try to avoid buying a policy that states premiums will go up with attained age.* Even if you purchase a policy prior to age 65, you should carefully examine what you buy.
- *Do not buy an individual long-term care insurance policy that is not "guaranteed renewable for life."* Policies that are individual, in other words not sold on a group basis, should be guaranteed renewable. This means that the insured person has the right to continue the policy as long as he or she continues to pay premiums.
- *Be truthful when responding to questions from insurers about long-term care insurance.* You will be asked a number of questions and/or you will need to submit a physician's report. These are used by insurance companies for health underwriting to determine how insur-

able you are and withholding information can jeopardize future claims or cause a policy to be cancelled.

- *Remember that the National Association of Insurance Commissioners (NAIC) has recently adopted long-term care insurance standards which States are now expected to adopt.*

FOR MORE INFORMATION

If you need additional help or assistance in purchasing Medicare supplemental or long-term care insurance, contact your State Insurance Department or State Agency on Aging. (See lists in the back of this report.) However, there are other avenues of assistance for you to pursue when purchasing a Medigap or long-term care insurance policy, only some of which are listed below.

—If one exists in your State, a health insurance counseling program. A list of States with counseling programs can be found in the back of this report.

—If your State does not have a counseling program (and even if it does), your local community may have some form of a counseling program. These counseling programs may be run by consumer advocate organizations, such as the American Association of Retired Persons, or even by insurance companies or agents. (Because of conflict of interest concerns, many advocates recommend avoiding counseling programs run by insurance companies.) Your local area agency on aging can tell you if a counseling program is near you.

—Senior centers frequently offer a variety of informational publications to local senior citizens. Ask your center if they have materials on Medigap and/or long-term care insurance.

—Local libraries also may have valuable background information on insurance and likely will have other informational publications.

—If you believe that you have been victimized by unfair, abusive, or fraudulent insurance practices, you may want the advice or assistance of an attorney. Your State or Area Agency on Aging can direct you to attorneys who provide low or no-cost legal services to older Americans.

Finally, included in the back of this report are forms which the California Department of Insurance prepared that can help guide you in choosing the supplemental insurance policy that best meets your needs.

STATE INSURANCE DEPARTMENTS

[Each State has its own laws and regulations governing all types of insurance. The offices listed in this section are responsible for enforcing these laws, as well as providing the public with information about insurance]

Alabama
Alabama Insurance Department
135 South Union Street
Montgomery, AL 36130-3401
(205) 269-3550

Alaska
Alaska Insurance Department
3601 C Street, Suite 740
Anchorage, AK 99503
(907) 562-3626

American Samoa
American Samoa Insurance Department
Office of the Governor
Pago Pago, AS 96797
011-684/633-4116

Arizona
Arizona Insurance Department
Consumer Affairs and Investigative Division
3030 N. Third Street
Phoenix, AZ 85012
(602) 255-4783

Arkansas
Arkansas Insurance Department
Consumer Service Division
400 University Tower Building
12th & University Streets
Little Rock, AR 72204
(501) 371-1813

California
California Insurance Department
Consumer Services Division
3450 Wilshire Boulevard
Los Angeles, CA 90010
1-800-233-9045

Colorado
Colorado Insurance Department
303 W. Colfax Ave., 5th Floor
Denver, CO 80204
(303) 620-4300

Connecticut
Connecticut Insurance Department
165 Capitol Avenue
State Office Building
Hartford, CT 06106
(203) 297-3800

Delaware
Delaware Insurance Department
841 Silver Lake Boulevard
Dover, DE 19901
(302) 736-4251

District of Columbia
District of Columbia Insurance Administration
613 G Street NW., Room 619
P.O. Box 37200
Washington, DC 20001-7200
(202) 727-8017

Florida
Florida Department of Insurance
State Capitol, Plaza Level Eleven
Tallahassee, FL 32399-0300
Toll-Free (Within State)
1-800-342-2762
(904) 488-0030

Georgia
Georgia Insurance Department
2 Martin L. King, Jr. Drive
Room 716 West Tower
Atlanta, GA 30334
(404) 656-2056

Guam
Guam Insurance Department
855 W. Marine Drive
P.O. Box 2796
Agana, GU 96910
011-671/477-1040

Hawaii
Hawaii Department of Commerce
and Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, HI 96811
(808) 548-5450

Idaho
Idaho Insurance Department
Public Service Department
500 S. 10th Street
Boise, ID 83720
(208) 334-3102

Illinois
Illinois Insurance Department
320 W. Washington Street, 4th Floor
Springfield, IL 62767
(217) 782-4515

Indiana
Indiana Insurance Department
311 W. Washington Street
Suite 300
Indianapolis, IN 46204
(317) 232-2395

Iowa
Iowa Insurance Division
Lucas State Office Building
E. 12th & Grand Sts., 6th Floor
Des Moines, IA 50319
(515) 281-5705

Kansas
Kansas Insurance Department
420 S.W. 9th Street
Topeka, KS 66612
(913) 296-3071

Kentucky
Kentucky Insurance Department
229 West Main Street
P.O. Box 517
Frankfort, KY 40602
(502) 564-3630

Louisiana
Louisiana Insurance Department
P.O. Box 94214
Baton Rouge, LA 70804-9214
(504) 342-5900

Maine
Maine Bureau of Insurance
Consumer Division
State House, Station 34
Augusta, ME 04333
(207) 582-8707

Maryland
Maryland Insurance Department
Complaints and Investigation Unit
501 St. Paul Place
Baltimore, MD 21202-2272
(301) 333-2792

Massachusetts
Massachusetts Insurance Division
Consumer Services Section
280 Friend Street
Boston MA 02114
(617) 727-7189

Michigan
Michigan Insurance Department
P.O. Box 30220
Lansing, MI 48909
(517) 373-0220

Minnesota
Minnesota Insurance Department
Department of Commerce
133 E. 7th Street
St. Paul, MN 55101
(612) 296-4026

Mississippi
Mississippi Insurance Department
Consumer Assistance Division
P.O. Box 79
Jackson, MS 39205
(601) 359-3569

Missouri
Missouri Division of Insurance
Consumer Services Section
P.O. Box 690
Jefferson City, MO 65102-0690
(314) 751-2640

Montana
Montana Insurance Department
126 N. Sanders
Mitchell Building
P.O. Box 4009, Room 270
Helena, MT 59604
Toll-Free (Within State)
1-800-332-6148
(406) 444-2040

Nebraska
Nebraska Insurance Department
Terminal Building
941 O Street, Suite 400
Lincoln, NE 68508
(402) 471-2201

Nevada
Nevada Department of Commerce
Insurance Division
Consumer Section
1665 Hot Springs Road
Capitol Complex
Carson City, NV 89701
(702) 687-4270

New Hampshire
New Hampshire Insurance Department
Life and Health Division
169 Manchester Street
Concord, NH 03301
(603) 271-2261

New Jersey
New Jersey Insurance Department
20 W. State Street
Roebling Building
Trenton, NJ 08625
(609) 292-4757

New Mexico
New Mexico Insurance Department
P.O. Box 1269
Santa Fe, NM 87504-1269
(505) 827-4500

New York
New York Insurance Department
160 W. Broadway
New York, NY 10013
New York City
(212) 602-0203
Toll-Free (Within State Outside of NYC)
1-800-342-3736

North Carolina
North Carolina Insurance Department
Consumer Services
Dobbs Building
P.O. Box 26387
Raleigh, NC 27611
(919) 733-2004

North Dakota
North Dakota Insurance Department
Capitol Building
5th Floor
Bismarck, ND 58505
(701) 224-2440

Ohio
Ohio Insurance Department
Consumer Services Division
2100 Stella Court
Columbus, OH 43266-0566
(614) 644-2673

Oklahoma
Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408
(405) 521-2828

Oregon
Oregon Department of Insurance and Finance
Insurance Division/Consumer Advocate
21 Labor and Industry Building
Salem, OR 97310
(503) 378-4484

Pennsylvania
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120
(717) 787-2317

Puerto Rico
Puerto Rico Insurance Department
Fernandez Juncos Station
P.O. Box 8330
Santurce, PR 00910
(809) 722-8686

Rhode Island
Rhode Island Insurance Division
233 Richmond Street, Suite 233
Providence, RI 02903-4233
(401) 277-2223

South Carolina
South Carolina Insurance Department
Consumer Assistance Section
P.O. Box 100105
Columbia, SC 29202-3105
(803) 737-6140

South Dakota
South Dakota Insurance Department
Enforcement
910 E. Sioux Avenue
Pierre, SD 57501-3940
(605) 773-3563

Tennessee
Tennessee Department of Commerce and Insurance
Policyholders Service Section
500 James Robertson Parkway
4th Floor
Nashville, TN 37243-0582
Toll-Free (Within State)
1-800-342-4029
(615) 741-4955

Texas
Texas Board of Insurance
Complaints Division
1110 San Jacinto Boulevard
Austin, TX 78701-1998
(512) 463-6501

Utah
Utah Insurance Department
Consumer Services
3110 State Office Building
Salt Lake City, UT 84114
(801) 530-6400

Vermont
Vermont Department of Banking and Insurance
Consumer Complaint Division
120 State Street
Montpelier, VT 05602
(802) 828-3301

Virgin Islands
Virgin Islands Insurance Department
Kongens Garde No. 18
St. Thomas, VI 00802
(809) 774-2991

Virginia
Virginia Insurance Department
Consumer Services Division
700 Jefferson Building
P.O. Box 1157
Richmond, VA 23209
(804) 786-7691

Washington
Washington Insurance Department
Insurance Building AQ21
Olympia, WA 98504-0321
Toll-Free (Within State)
1-800-562-6900
(206) 753-7300

West Virginia
West Virginia Insurance Department
2019 Washington Street, E.
Charleston, WV 25305
(304) 348-3386

Wisconsin
Wisconsin Insurance Department
Complaints Department
P.O. Box 7873
Madison, WI 53707
(608) 266-0103

Wyoming
Wyoming Insurance Department
Herschler Building
122 W. 25th Street
Cheyenne, WY 82002
(307) 777-7401

STATE AGENCIES ON AGING

[The offices listed in this section are responsible for administering and coordinating services for older Americans on a statewide basis]

Alabama
Commission on Aging
136 Catoma Street
Montgomery, AL 36130
Toll-Free (Within State)
1-800-243-5463
(205) 242-5743

Alaska
Older Alaskans Commission
P.O. Box C, MS 0209
Juneau, AK 99811
(907) 465-3250

American Samoa
Territorial Administration on Aging
Government of American Samoa
Pago Pago, AS 96799
(684) 633-1251

Arizona
Department of Economic Security
Aging and Adult Administration
1400 W. Washington Street
Phoenix, AZ 85007
(602) 542-4446

Arkansas
Division of Aging and Adult Services
Donaghey Plaza South, Suite 1417
7th and Main Streets
P.O. Box 1417/Slot 1412
Little Rock, AR 72203-1437
(501) 682-2441

California
Department of Aging
1600 K Street
Sacramento, CA 95814
(916) 322-3887

Colorado
Aging and Adult Services
Department of Social Services
1575 Sherman St., 10th Floor
Denver, CO 80203-1714
(303) 866-3851

Commonwealth of the Northern Mariana Islands
Department of Community and Cultural Affairs
Civic Center
Commonwealth of the Northern Mariana Islands
Saipan, CM 96950
(670) 234-6011

Connecticut
Department of Aging
175 Main Street
Hartford, CT 06106
Toll-Free (Within State)
1-800-443-9946
(203) 566-7772

Delaware
Division of Aging
Department of Health and Social Services
1901 N. DuPont Highway
New Castle, DE 19720
(302) 421-6791

District of Columbia
Office on Aging
Executive Office of the Mayor
1424 K Street N.W., 2nd Floor
Washington, D.C. 20005
(202) 724-5626
(202) 724-5622

Federated States of Micronesia
State Agency on Aging
Office of Health Services
Federated States of Micronesia
Ponape, E.C.1. 96941

Florida
Office of Aging and Adult Services
1317 Winewood Boulevard
Tallahassee, FL 32301
(904) 488-8922

Georgia
Office of Aging
Department of Human Resources
878 Peachtree Street, NE
Room 632
Atlanta, GA 30309
(404) 894-5333

Guam
Division of Senior Citizens
Department of Public Health and Social Services
P.O. Box 2816
Agana, GU 96910
(671) 734-2942

Hawaii
Executive Office on Aging
335 Merchant Street
Room 241
Honolulu, HI 96813
(808) 548-2593

Idaho
Office on Aging
Statehouse, Room 114
Boise, ID 83720
(208) 334-3833

Illinois
Department on Aging
421 E. Capitol Avenue
Springfield, IL 62701
(217) 785-2870

Indiana
Department of Human Services
251 North Illinois
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7020

Iowa
Department of Elder Affairs
Suite 236, Jewett Building
914 Grand Avenue
Des Moines, IA 50319
(515) 281-5187

Kansas
Department on Aging
122-S. Docking State Office Building
915 SW Harrison
Topeka, KS 66612-1500
(913) 296-4986

Kentucky
Division for Aging Services
Department for Social Services
275 E. Main Street
Frankfort, KY 40621
(502) 564-6930

Louisiana
Governor's Office of Elderly Affairs
P.O. Box 80374
Baton Rouge, LA 70898-0374
(504) 925-1700

Maine
Maine Committee of Aging
State House, Station 127
Augusta, ME 04333
(207) 289-3658

Maryland
State Agency on Aging
301 W. Preston Street
Baltimore, MD 21201
(301) 225-1102

Massachusetts
Executive Office of Elder Affairs
38 Chauncy Street
Boston, MA 02111
Toll-Free (Within State)
1-800-882-2003
(617) 727-7750

Michigan
Office of Services to the Aging
P.O. Box 30026
Lansing, MI 48909
(517) 373-8230

Minnesota
Minnesota Board on Aging
Human Services Building
4th Floor
444 Lafayette Road
St. Paul, MN 55155-3843
(612) 296-2770

Mississippi
Council on Aging
301 W. Pearl Street
Jackson, MS 39203-3092
Toll-Free (Within State)
1-800-222-7622
(601) 949-2070

Missouri
Division of Insurance
Truman Building 630
P.O. Box 690
Jefferson, MO 65102-0690
Toll-Free (Within State)
1-800-235-5503

Montana
Department of Family Services
P.O. Box 8005
Helena, MT 59604
(406) 444-5900

Nebraska
Department on Aging
State Office Building
301 Centennial Mall South
Lincoln, NE 68509
(402) 471-2306

Nevada
Department of Human Resources
Division for Aging Services
505 E. King Street
Room 101
Carson City, NV 89710
(702) 885-4210

New Hampshire
Department of Health and Human Services
Division of Elderly and Adult Services
6 Hazen Drive
Concord, NH 03301
(603) 271-4394

New Jersey
Department of Community Affairs
Division on Aging
S. Broad and Front Streets
CN 807
Trenton, NJ 08625-0807
(609) 292-0920

New Mexico
Agency on Aging
La Villa Rivera Building
4th Floor
224 E. Palace Avenue
Santa Fe, NM 87501
Toll-Free (Within State)
1-800-432-2080
(505) 827-7640

New York
State Office for the Aging
Agency Building
2 Empire State Plaza
Albany, NY 12223-0001
Toll-Free (Within State)
1-800-342-9871
(518) 474-5731

North Carolina
Department of Human Resources
Division of Aging
1985 Umstead Drive
Raleigh, NC 27603
(919) 733-3983

North Dakota
Department of Human Services
Aging Services Division
State Capitol Building
Bismarck, ND 58505
(701) 224-2577

Ohio
Department of Aging
50 W. Broad Street
8th Floor
Columbus, OH 43266-0501
(614) 466-1221

Oklahoma
Department of Human Services
Aging Services Division
P.O. Box 25352
Oklahoma City, OK 73125
(405) 521-2327

Oregon
Department of Human Services
Senior Services Division
313 Public Service Building
Salem, OR 97310
Toll-Free (Within State)
1-800-232-3020
(503) 378-4636

Palau
State Agency on Aging
Department of Social Services
Republic of Palau
Koror, Palau 96940

Pennsylvania
Department of Aging
231 State Street
Barto Building
Harrisburg, PA 17101
(717) 783-1550

Puerto Rico
Governors Office of Elderly Affairs
Gericulture Commission
Box 11398
Santurce, PR 00910
(809) 722-2429 or 722-0225

Republic of the Marshall Islands
State Agency on Aging
Department of Social Services
Republic of the Marshall Islands
Marjuro, Marshall Islands 96960

Rhode Island
Department of Elderly Affairs
160 Pine Street
Providence, RI 02903
(401) 277-2858

South Carolina
Commission on Aging
400 Arbor Lake Drive
Suite B-500
Columbia, SC 29223
(803) 735-0210

South Dakota
Agency on Aging
Adult Services and Aging
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3656

Tennessee
Commission on Aging
706 Church Street
Suite 201
Nashville, TN 37219-5573
(615) 741-2056

Texas
Department on Aging
P.O. Box 12786
Capitol Station
Austin, TX 78711
(512) 444-2727

Utah
Division of Aging & Adult Services
120 North 200 West
P.O. Box 45500
Salt Lake City, UT 84145-0500
(801) 538-3910

Vermont
Office on Aging
Waterbury Complex
103 S. Main Street
Waterbury, VT 05676
(802) 241-2400

Virgin Islands
Department of Human Services
Barbel Plaza South
Charlotte Amalie
St. Thomas, VI 00802
(809) 774-0930

Virginia
Department for the Aging
700 Centre, 10th Floor
700 E. Franklin Street
Richmond, VA 23219-2327
Toll-Free (Within State)
1-800-552-4464
(804) 225-2271

Washington
Aging & Adult Services Administration
Department of Social & Health Services
Mail Stop OB-44-A
Olympia, WA 98504
(206) 586-3768

West Virginia
Commission on Aging
State Capitol Complex
Holly Grove
Charleston, WV 25305
Toll-Free (Within State)
1-800-642-3671
(304) 348-3317

Wisconsin
Bureau on Aging
Department of Health & Social Services
P.O. Box 7851
Madison, WI 53707
Toll-Free (Within State)
1-800-242-1060
(608) 266-2536

Wyoming
Commission on Aging
Hathaway Building
First Floor
Cheyenne, WY 82002
Toll-Free (Within State)
1-800-442-2766
(307) 777-7986

STATE HEALTH INSURANCE COUNSELING PROGRAMS

California
Mr. Wayne R. Lindley
California Department of Aging
Program Manager
Health Insurance Counseling and Advocacy Program (HICAP)
K Street
Sacramento, CA 95814
(916) 323-7315

Illinois
Ms. Bernadette Nolan
Program Director
Senior Health Insurance Program (SHIP)
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767
(217) 782-0004

Maryland
Ms. Michelle Holzer
Coordinator of Senior Health Insurance Counseling Program (SHICP)
Maryland Office on Aging
301 West Preston Street
Baltimore, MD 21201
(301) 225-1270

New Mexico
Ms. Denese Mueller
Program Manager
Health Insurance Benefits Assistance Program (HIBAC)
New Mexico Agency on Aging
224 East Palace Ave.
Fourth Floor
Santa Fe, NM 87501
(505) 827-7640

Idaho
Mr. Ken Hurt
Program Specialist
Senior Health Insurance Benefits Advisors (SHIBA)
Idaho Department of 1600 Insurance
500 S. 10th Street
Boise, ID 83720
(208) 334-2250

Iowa
Ms. Kris Gross
Senior Health Insurance Advocate
Protection & Advocacy Through Community Training, Iowa Insurance Division (PACT)
Lucas State Office Building
Sixth Floor
Des Moines, IA 50319
(515) 242-5190

Massachusetts
Ms. Maureen Barton
Program Director
Serving Health Information Needs of Elders (SHINE)
Executive Office of Elder Affairs
38 Chauncey Street
Boston, MA 02111

New Jersey
Ms. Theresa Dietrich
Coordinator: Senior Health Insurance Program (SHIP)
Department of Community Affairs
Division of Aging
CN 807
Trenton, NJ 08625
(609) 292-4303

North Carolina
Ms. Alice Garland
Assistant Commissioner
Department of Insurance
Senior Health Insurance Information Program (SHIIP)
P.O. Box 26387
Raleigh, NC 27611
(919) 733-0433

Ohio (Pilot Program)
Mr. Joseph Mancini
Office of Attorney General
Health, Education and Human Services Section
State Office Tower
30 East Broad Street
Columbus, OH 43215
(614) 466-8600

Washington
Ms. June Mulkahey
Deputy Commissioner
Senior Health Insurance Benefits Advisors (SHIBA)
Insurance Building
Olympia, WA 98504
(206) 753-2408

Wisconsin
Ms. Jane Raymond
Benefit Specialist Program Liaison
Wisconsin Bureau on Aging
1 West Wilson Street
P.O. Box 7851
Madison, WI 53707
(608) 266-2568

FORM A

YOUR HEALTH INSURANCE POLICY INVENTORY

Use this form to list each of your current health policies. The information will help you evaluate your present insurance coverage and whether you need additional coverage. Keep the form and your policies in a safe place for reference.

BE SURE TO KEEP A COPY OF THIS FORM. DO NOT GIVE YOUR ONLY COPY TO AN AGENT.

	Insurance Company	Policy #	Type of Policy	Effective Date	Expiration Date	Premium
1.						
2.						
3.						
4.						
5.						

FORM B

AGENT IDENTIFICATION SHEET

Use this form to obtain information on any insurance agent who contacts you regarding the purchase of Medigap health insurance. Keep it with your insurance policies and other forms in a safe place. It will ensure that you know who you are dealing with and how you can contact that agent if necessary. The information can also be used to check out the agent with your local Better Business Bureau and the State Department of Insurance.

Agent's Name: ______________________________

Agent's License Number: ______________________________

Agent's Business Address: ______________________________

____

____

____

Agent's Telephone Number: ______________________________

Name(s) of Insurance Company or Companies Represented by Agent: ______________________________

____

____

____

Date 1st Contacted by Agent: ______________________________

Date(s) of Subsequent Calls by Agent: ______________________________

____

____

FORM C

AGENT CERTIFICATION OF INSURANCE SALE

Ask any agent wanting to sell you Medigap Insurance to review form A, which lists your current health insurance coverage. If, after reviewing your inventory of existing policies, the agent feels you need additional coverage, ask him or her to complete this form. It will explain why the agent feels your present coverage is inadequate and why more insurance will benefit you. The agent is not required to sign this form, but you may choose not to do business with any agent who refuses.

I, the undersigned agent, hereby certify that I have reviewed and evaluated ______________________ 's health insurance policy inventory
(enter applicant's name)
consisting of the following policies:

Insurance Company	Policy #
1.	
2.	
3.	
4.	

Based on my evaluation, I have recommended that
______________________ purchase additional insurance as follows:
(enter applicant's name)

Insurance Company	Type of Policy	Policy Form #
1.		
2.		

This additional insurance is necessary for the following reasons:

____
(Agent's Signature)

FORM D

POLICY COMPARISON SHEET AND AGENT CERTIFICATION FORM

This form should be used when you are considering replacing an existing policy with a new one. It will allow you to compare your current insurance coverage against the proposed new one.

Ask the agent to list and compare the benefits and features of the new versus the old policy. The form asks the agent to list the reasons why it is in your best interest to replace your existing policy.

A. Benefits	Existing Policy No. ______	Proposed Policy Form No. ______
1.		
2.		
3.		
4		
5.		
6.		
B. Premium		
C. Is a pre-existing condition coverage?	Yes or No. If "yes" the waiting period is ______	Yes or No. If "yes" the waiting period is ______
D. Is the policy guaranteed renewable?	☐ Yes or ☐ No	☐ Yes or ☐ No

AGENT CERTIFICATION

I, the undersigned agent, have analyzed and compared ______________________
(enter applicant's name)
existing policy or policies to the proposed policy and conclude that it is in the insured's best interest to replace the existing policy or policies with the proposed policy based on the following reasons:

____

____

____

Further, I have considered that the insured may be eligible to upgrade his/her coverage with the existing insurer, but I have advised against that for the following reasons:

____

____

____

____
(Agent's Signature)

FORM E

INSURANCE BUYER'S CHECKLIST

Before you sign any documents or pay any amount to the agent, be sure that you have:

- ☐ Completed your Health Insurance Policy Inventory (Form A).
- ☐ Carefully reviewed the application for insurance to ensure that each question is answered correctly.
- ☐ Received and understand each of the following items:
    - ☐ Outline of Coverage for the Proposed Policy. (Not included in this kit, but the agent is required by law to provide you with this.)
    - ☐ "Guide to Health Insurance for People with Medicare" published by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Dept. of Health and Human Services. (Not included in this kit, but the agent is required by law to provide you with this.)
    - ☐ Agent Identification Sheet (Form B).
    - ☐ Agent Certification of Insurance Sale (Form C).
    - ☐ Policy Comparison Sheet and Agent Certification Form (if you are replacing your current policy with another—Form D).
    - ☐ Replacement Notice—if you are replacing your current policy with another. (Not included in this kit, but the agent is required by law to provide you with it.)

Item 2

A Winning Game Plan Scores More Sales More Often...

Build a real pro's winning sales strategy with

Pre-Qualified Leads an
Targeted Name Lists.

A Presentation Of:

ARM/ASCA

American Response Marketing
— and —
American Senior Citizens Association

Sales Success Results From A Winning Game Plan.

Build Your Game Plan With A Sales Strategy Based On The Best Pre-Qualified Leads And Sales Lists Available Today.

▶ Mailing List Information

Businesses of all types across the United States rely upon us for specialized lists that consistently deliver excellent results in a variety of sales and marketing situations. Regardless of your business, service or product, we provide lists that help you pinpoint and target your highest potential prospects. Our lists utilize the best sources and are continually updated and cleaned to assure quality. Look at the following selection of lists and then call us to discuss how they can help build your winning sales strategy. Remember, we can develop a list customized to meet your individual needs. So *even if you don't see exactly what you need, be sure to call us with your requirements.*

▶ Senior Citizens

Selections in this affluent and highly responsive market can be carefully tailored to your product and marketing area. Excellent potential for Insurance, Hearing Aids and other Health Care Products and Services, Travel Services, Specialty Mail Order Products, Financial Services, and much more.

Seniors
  50-54
  55-59
  60-64
  65 +

▶ Wealthy Americans

Tap into these categories representing households with maximum disposable income based upon median family income levels. Represents excellent potential for luxuries, extras, financial and high ticket items.

Wealthy Americans
  35-65 with
  Median Family Income
  $50M +

▶ Rural America

Individuals living in small towns and rural areas throughout the U.S. A segment traditionally highly responsive to direct mail and direct marketing.

Rural America
  by Age
  By Address Type (i.e. Rural Route, etc.)

▶ Farmers and Ranchers

Independent business people who are the heartblood of the agricultural industry in the U.S. Responsive to all business services and products as well as specialized agricultural offers.

Farmers and Ranchers
  By crop
  By livestock type
  By acreage

▶ Small Business Owners

America's biggest employer and fastest growing business segment. A market with enormous demand for business services, supplies and equipment.

Small Business Owners
  By employee size
  By business type

▶ Higher Learning Student Profiles

Ambitious young Americans who are going places. Excellent potential for student loans, insurance, college and vocational recruitment and many other student responsive products and services.

Student Profiles
  15-24 years

Build Your Winning Sales Strategy With American Response Marketing's Easy Five-Step Sales Lead or Name List Tactics.

Sales Lead Game Plan

1. Define the target area where you need sales leads — by Zip Code, County, SCF, or State. List in priority order. Be sure to choose a large enough area to obtain all of the leads that you need.
2. Define who your best customer prospects are by: Age Range, Household Income, Race, Sex, Marital Status, Type of Business, Number of Employees, etc.
3. Define how many leads PER WEEK you need for all sales representatives combined.
4. Call one of our Professional Sales Consultants. Telephone TOLL FREE 1 (800) 992-2722. In Texas, 1 (800) 654-2722. Discuss the type of package which will work best for you. Obtain your list counts and quotations for mailing or cost per lead estimates. You may place your order by phone. We accept VISA and MasterCard.
5. Send your confirmation order and payment. Almost immediately* you begin getting ***quality prospects*** (not suspects) that help you win with increased sales.

Name List Game Plan

1. Define the target area where you need sales leads — by Zip Code, County, SCF, or State. List in priority order. Be sure to choose a large enough area to obtain all of the names that you need.
2. Define who your best customer prospects are by: Age Range, Household Income, Race, Sex, Marital Status, Type of Business, Number of Employees, etc.
3. Call one of our Professional Sales Consultants. Telephone TOLL FREE 1 (800) 992-2722. In Texas, 1 (800) 654-2722. Obtain your list counts, minimum order quantities and current pricing. Ask about volume discounts.
4. Simply fill out the ORDER FORM and mail it with your payment, or give the List Specialist your order over the telephone. We accept VISA and MasterCard.
5. Almost immediately,' you begin winning with increased sales. By using the best lists available, you avoid unproductive down time wasted on prospecting.

*Typical time frame from order to leads is 4 weeks

'Normal delivery on name lists is 10 working days

SOCIAL SECURITY

IMPORTANT 1989 BENEFITS UPDATE

The following information is extremely important to you and your family.

If you are between the ages of 50 and 85, you may qualify for a Social Security Funeral Expense Benefit. However, this benefit is thousands of dollars below the total cost of today's funeral expense.

Return the postage paid reply card today and you will receive information on this benefit and information on a final expense program designed to pay those expenses not paid by the Social Security benefit plan.

If you are between 50 and 85 years of age, you may qualify to receive information on a final expense program that will pay up to **$10,000** to your beneficiary.

This plan was designed to prevent the excessive cost placed on your survivors.

It is very important that you know all the benefits available to you. To receive more information on this plan designed for today's seniors, return the postage paid Information Request Card today.

American Health Referral Group
Social Security Death Benefits Southwest Regional Office
Ft. Worth, TX 76161-9962

Detach this card and mail today!

Name ______________________
Add. ______________________
City/State ______________________

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS PERMIT 1858 FORT WORTH, TEXAS

POSTAGE WILL BE PAID BY ADDRESSEE

AMERICAN HEALTH REFERRAL GROUP
SOCIAL SECURITY DEATH BENEFITS
SOUTHWEST REGIONAL OFFICE
P.O. BOX 164069
FT. WORTH, TEXAS 76161-9962

NO COST OR OBLIGATION

☐ **YES! Please see that I receive the information on the final expense programs designed for today's seniors!**

Name ____________________

Street ____________________

City ____________________

State __________ Zip __________

County ____________________

Age: Husband ______ Wife ______

Phone (   ) ____________________

AC1

____

Signature

(NOTE!) Area code & phone number insure proper information routing.

BENEFITS
INFORMATION REQUEST

CAR-RT SORT **CR20
WILLIAM T. FLYNN
7710 W RIM
AUSTIN, TX 78731

American Health Referral Group is not affiliated with any Government Agency. Your response will be used in an insurance solicitation by a Private Insurance Company.

SOCIAL SECURITY
1989
Death Benefits Update

AMERICAN HEALTH REFERRAL GROUP
SOCIAL SECURITY DEATH BENEFITS S.W. REGIONAL OFFICE
P.O. BOX 164069
FT. WORTH, TX 76161-9962

BULK RATE
U.S. POSTAGE
PAID
Permit No.14
Dallas, TX

Postmaster: If undeliverable to address, process according to U.S. Postal Regulation No. 694

CHRISTIAN
BROTHERHOOD

530 Bedford Rd. Bedford, Texas 76022 817/282-7017

Important Notice
To All Church Members

Dear Member:

We are providing information about a program of total Medicare Supplement protection.

A most significant feature is that it **pays 100% of the difference** between what a doctor charges and what Medicare pays. That is, payments are not limited to Medicare "approved" charges. This program simply pays the difference . . . **all of it!** Of course, it also pays the deductibles under Part A Medicare.

The purpose of our inquiry is to verify interest in a truly complete package of Medicare Supplement coverage at an exceptionally favorable cost.

To this end, we would appreciate your cooperation in filling out the questionnaire on the reverse side. A postage paid envelope is enclosed. Thank you for your attention.

Bob Rogers

Bob Rogers
Christian Brotherhood

Form S100

1. In terms of hospital and medical coverage, how would you describe your present policy?
   ☐ Very Adequate
   ☐ Moderate
   ☐ Poor

2. Are you concerned about rising costs of hospital and doctor's services?
   ☐ Yes
   ☐ No

3. Will your present policy pay 100% of the actual difference between the amount paid by Medicare and the physicians' and surgeons' charges?
   ☐ Yes
   ☐ No

4. Assuming the costs were reasonable, would you be interested in seeing a plan such as described here made available to church members?
   ☐ Yes
   ☐ No

Thank You For Your Help

Please return the questionnaire in the enclosed postage paid envelope.

Name____________________ Age________

Address____________________ Phone________

City______________ State______ Zip________

County________ Church____________________

** REPEAL OF MEDICARE **
CATASTROPHIC COVERAGE ACT OF 1988

ON JANUARY 1, 1990 THERE WILL BE CHANGES MADE TO MEDICARE. EVEN THOUGH THE VAST MAJORITY WILL NOT BE AFFECTED BY EITHER THE 1989 PART A OR THE 1990 PART B CHANGES. CO-INSURANCE (CAP) THIS MEANS THE AMERICAN SENIOR CITIZENS WILL STILL NEED A QUALITY MEDICARE SUPPLEMENT PLAN, THAT WILL HELP PAY EXPENSES NOT PAID BY MEDICARE. IF YOU WOULD LIKE INFORMATION ON HOW THE NEW LAW WILL EFFECT YOU AND WHAT INSURANCE PROTECTION YOU STILL NEED, JUST COMPLETE AND MAIL THIS FREE CARD TODAY.

( ) HOW I CAN BECOME A MEMBER OF A.S.C.A.
( ) LONG TERM NURSING HOME PLAN
( ) NEW CHANGES TO MEDICARE
( ) SENIOR CITIZENS FINAL EXPENSE PLAN
( ) MEDICARE SUPPLEMENT PLAN ( ) 100% ( ) 50% ( ) 20%

X------------------------------ SIGNATURE

---------------- PLEASE VERIFY COUNTY

-------- AGE

--------- SPOUSE

( ) ------------ AREA PHONE

** CAR-RT SORT **CR54
6502 . - 1280
MS ELLA V ADAMS
107 DEL RIO CT #1
VACAVILLE, CA 95687

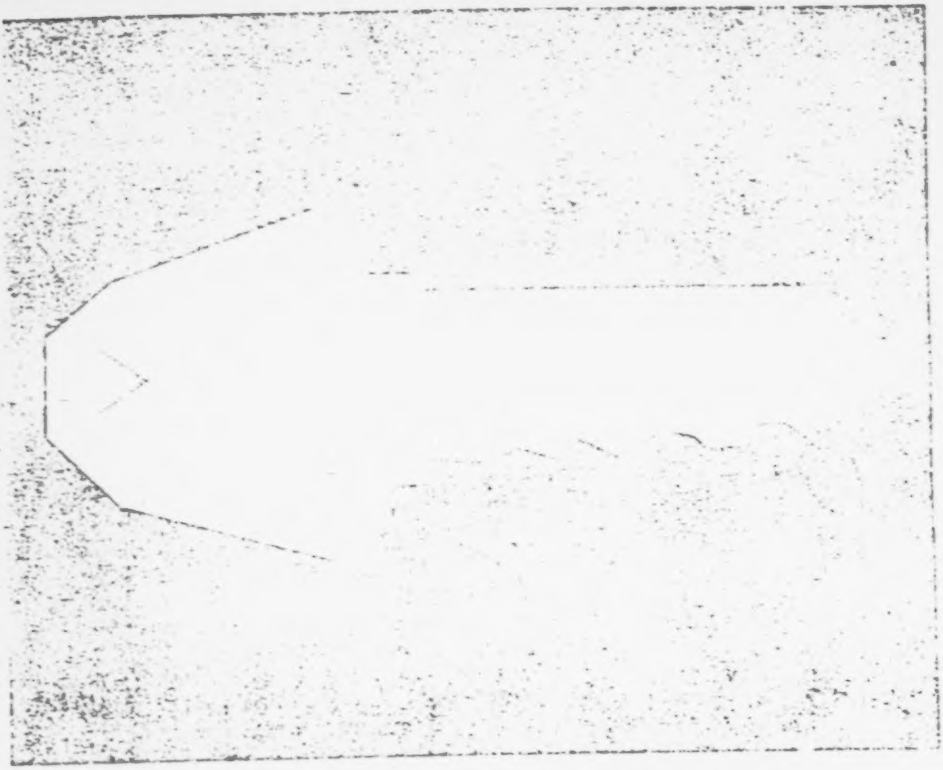
BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 15583 WASHINGTON, D.C.
POSTAGE WILL BE PAID BY ADDRESSEE

A.S.C.A.
PROCESSING OFFICE
655 15th STREET, N.W. #315
WASHINGTON, D.C. 20005-9990

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

Item 3

Your Key To Professional Selling



A&H Product Training Manual

Standard Life
AND ACCIDENT
INSURANCE COMPANY

A MEMBER OF THE AMERICAN NATIONAL FAMILY OF COMPANIES

THOMAS M. POTEET, JR., ASSISTANT VICE PRESIDENT
ASSISTANT DIRECTOR OF MARKETING

TO ALL NEW STANDARD LIFE AGENTS:

Please accept my congratulations on your decision to join Standard Life. You have made a wise and rewarding choice.

Insurance agents, as you perhaps know, are among the best paid professionals in the world, and Standard Life agents are among the best paid in the insurance industry. There are many good reasons for this and this training manual is just one of them.

You will be expected to virtually memorize every section of this book. However, the rewards for doing so are exceptionally high. Your policyowners will be well served by an insurance expert and your family will bask in the financial fruits of your success; while you will experience a great sense of personal accomplishment.

My best wishes for your personal success.

Sincerely,

Thomas M. Poteet, Jr.

Thomas M. Poteet, Jr.

Selling Principles

Simply stated, selling is a matter of action and reaction. Everything you say and do, your every action should provoke a desired reaction. The purpose of this section is to aid you in developing your actions and directing your prospect's reactions.

We have discussed your mental attitude. Again, your state of mind has a direct bearing on your actions and your prospect's reactions. It is of far less importance how your prospect thinks. . . and far more important how you think. Condition your mind before entering a home. Eliminate the negatives. Tell yourself "This is going to be the best presentation I've ever given." Or, "I believe": "I *believe* this is a wonderful policy." "I *believe* this prospect needs this policy." "I *believe* he can afford it." "I *believe* I can sell him." And from this point, it's easy to knock on the door and say, "I *believe* this will interest you."

EMPLOY PROVEN PRINCIPLES.

The first step is to know your product and how to present it. And this is accomplished by memorizing the organized sales talks in the preceding section. Memorize them well. Memorize them so well, you can employ each with ease. Memorize them so well that you know, not only *what* you're going to say, but *how* you're going to say it. This takes time and practice, practice, practice! In the end, however, you will save time because you will know exactly what words to use. You will present every feature and benefit of the policy in its proper, most effective sequence, without overlooking anything. You will avoid misrepresentations. You will be confident because you know you are using proven, time-tested, successful methods. And you will make more money because each presentation is designed to *sell!*

Be a good actor! That's right, be a good actor. Salesmen are often like actors. Your presentation is your script. Your prospect is your audience. Learn your scripts. Give your sales presentation and rebuttals word for word. Learn them so well that they are natural and convincing. Learn them so well that you can put feeling and personality in your presentations. It will never occur to a prospect that you have learned what to say and do, anymore than it occurs to you, as you watch a movie or stage play, that the actor has learned his lines and is following prescribed stage directions. A good salesman, like a good actor, lives his part. Be a good actor. Learn your lines well.

Be enthusiastic! Memorize these six points, use them and you will always be enthusiastic.

- **Talk loudly**
- **Talk rapidly**
- **Keep a smile in your voice**
- **Use emphasis**
- **Hesitate**
- **Modulate**

When you **talk loudly** and **rapidly**, timidity and fear disappear. Many beginners, from salesmen to after-dinner speakers, are afraid. But the experts agree, forcing yourself to speak up loudly and rapidly will transform fear into courage and doubts into conviction.

A smile in your voice is evidence of a pleasing personality. Equally important, it helps you avoid appearing gruff. This is especially important for a beginner, whose voice tends to sound gruff when he speaks loudly. The best way to put a smile in your voice is to put a smile on your face.

Emphasize words that are important to you and your prospect. "You," "Also," "Only." These are all important words in selling.

Strategic Hesitation in your presentation play an important role. When you read you mentally hesitate at commas, periods and other punctuation marks. When you speak, you should hesitate at these same points—especially when you speak rapidly. This helps clarify your meaning and allows the prospect to keep pace with the ideas you are presenting.

Modulation takes practice. Beginners need not be quite so concerned with modulation. However, the experienced salesman should always be aware of modulation to avoid becoming stale. Over a period of time, his presentation comes more easily and more rapidly. It almost appears mechanical. He must emphasize, hesitate and modulate in order to keep his sales presentation sounding natural and spontaneous. There are places in your presentation where you should slow down. Others where speed is called for. Still others which call for raising your voice; then lowering it to a slow, deliberate pace.

Don't be a foreigner. When you start to work, don't brand yourself as a rookie. Eliminate such phrases as: "I just got started"; "I don't know anyone out here"; . . . a lot of your local people." Instead, read the newspapers. Use the names of local people who have had accidents. Use all the "live apps" of people now enrolled in the plan as possible.

Avoid negative questions and agreements. Many salesmen echo a prospect's negative statement by repeating it. This is usually an unconscious reaction aimed at relieving the tension or gaining a few seconds in which to think. For example:

Prospect: *"I wouldn't be interested."*
Salesman: *"You wouldn't be interested then?"*

• • • •

Prospect: *"I'm loaded with insurance."*
Salesman: *"You mean you have more than you need?"*

• • • •

Prospect: *"I don't believe in insurance."*
Salesman: *"You don't?"*

Other common reactions are such phrases as: "I see"; or "uh-huh." All these do is reinforce the prospect's negative statement. This is usually habit—and with concentration, can be easily broken. Instead of agreeing, ask a question that advances your sale by directing your prospect's mind away from this negative area, such as: "Do you drive a car?" or "Do you carry accident insurance." You will not only relieve the tension, but also obtain a few valuable seconds to collect your thoughts.

Focus your prospect's attention. The mind is a wondrous machine. It is capable of focusing on many thoughts at once. Or it can focus on one thought. It can concentrate. Or it can wander. Your success is dependent on keeping your prospect's mind concentrated and attentive to one thought: your presentation. You have three forces at your disposal to accomplish this: your eyes, your voice and your actions.

Many salesmen fail to realize what a powerful, compelling force they possess in their eyes. We are taught to look a person in the eye when we talk to them. Most people are distrustful of anyone who fails to do so. As you are conversing, look at your prospect's eyes and he will look at yours. His thoughts will be concentrated on you and what you are saying.

Your eyes can also be used to direct your prospect's attention elsewhere. When speaking of the policy features, turn your eyes to the policy, point with your pen and the prospect's eyes will follow.

The enthusiasm in your voice is another compelling force. Your speaking volume, your inflection, the ease and authority with which you speak all serve to concentrate your prospect's thoughts to the business at hand.

Combine these forces and you force your prospect's mind to concentrate on your presentation and push distractions from his thoughts.

Generally, you look your prospect in the eye when: you ask a question, such as "Isn't it possible that you could have an accident in the next six months?" Or you make an exclamation, "Just think of it." A statement of fact, "This is splendid protection for such a low cost."

You look away and redirect your prospect's eyes when: 1) you point to a policy feature and look at the word or sentence to which you're pointing; 2) you point to the names of local people who own the protection.

Avoid interruptions. The objective of your presentation is to complete your sales talk and show the policy without interruption. Interruptions are nearly inevitable. However, to minimize them, make your presentation lively. Don't be automatic. Think of what you're saying and how you sound to your prospect. Put excitement in your voice. Smile.

When you are interrupted, here are a few statements to help you get back on the track.

- *"That's just why you need this coverage. Here, let me show you. . . ."*
- *"I'm glad you mentioned that. Nearly everyone I talk with has some type of medical insurance. As I was saying, this works with your existing coverage, supplementing it. . . ."*
- *"Really? I didn't know that. Now, as I was saying. . . ."*
- *(TO AN INTERRUPTION ASKING FOR INFORMATION) "I'll answer that in just a minute." (OR) "You'll recall, I mentioned, a few minutes ago. . . ."*
- *"Many people think that. And I'll get to it in just a minute."*

Another important tip: break eye contact when you are interrupted. This allows you to divert the prospect's attention and direct it back to the policy. Don't wait for a reaction after you've countered an interruption. Assume he has said "Okay" or "go ahead," and continue with your presentation.

THE SIX STEPS OF SELLING.

Nearly every form of human activity is performed in some sequence. One step must be completed before the next can take place.

The same is true of selling. A sale is completed one step at a time in a pre-

[redacted]

scribed sequence. You cannot close a sale until you have made a presentation. You cannot make a presentation until you have established a need. You cannot establish this need until you have gained the prospect's confidence. You cannot gain the prospect's confidence until you have located this prospect and arranged an appointment. In reverse order, those are the six steps of selling, and we will now take them one by one.

1. PROSPECTING

One of the main reasons for failure in the insurance business is the failure to prospect. In order to make sales, you must have customers. And unlike many other selling positions, insurance customers do not walk in the door. You have to go out and find them. You have to prospect.

Prospecting is time-consuming. The other five steps to selling, combined, take about one-third of your time. Prospecting, alone, takes the other two-thirds.

In insurance sales there are many ways of prospecting. The most common and successful methods are: policyowner files; referrals from customers (Always ask a customer for the names of their friends, relatives and neighbors. This "implied endorsement" is powerful selling medicine.); newspaper reports of marriages, new homes, other changes in life; newspaper accounts of serious local accidents, which can work a considerable influence on prospects dramatizing the value of insurance; advertising for leads; or cold canvassing by telephone or door-to-door.

2. APPROACHING YOUR PROSPECT AND MAKING APPOINTMENT

You've heard it said, a sale is made in the first 30-seconds. There is no doubt, the first few minutes are crucial. If you fail to get in the door or set an appointment, you certainly will fail to make a sale. Many things contribute to your success or failure in these opening seconds: your appearance, your attitude, what you say and how you say it.

Make those first 30-seconds count for *you!* We've talked about appearance and attitude. Now we're going to talk about *what to say.* Remember! Don't get the cart before the horse. Take the sale step by step. Only tell the prospect enough about the product to arouse their curiosity and interest.

COLD CANVASSING

"Mr. Prospect, my name is_________, with Standard Life and Accident Insurance Company. Frankly, I have no idea at this moment whether you have need of my services. However, I have an idea which has proved so valuable to your neighbors and other people, that you might be interested. It will just take a few minutes—and you can decide for yourself. Fair enough? May I come in?"

* * * *

"Mr. Prospect, my name is_________, with Standard Life and Accident Insurance Company. I'd like to ask you a couple of questions. With which company do you carry hospitalization insurance? Good. And does their plan pay you if you are hospitalized for as long as 365 days? The reason I asked you these questions, we have a brand-new hospitalization plan that I know you'll be interested in. May I come in for a few moments and show you how it works?"

* * * *

"Hello. My name is_________. I'm with the Survey Division of Standard Life and Accident Insurance Company. We're taking a survey of hospital insurance coverage in this area, and I'd like to ask you a

few questions. May I come in? (IF THE PROSPECT REFUSES, CONTINUE:) That's alright. I can ask you as well out here. Do you now carry hospitalization insurance? With what company? Have you used it within this past year? Does it offer extended coverage? Here, let me show you what I mean. May I come in so I can spread out these pictures?"

POLICYOWNERS

"Mr.--------? My name is-------- with Standard Life and Accident Insurance Company. I believe you're one of our policyowners? I'd like to discuss your coverage with you. May I come in? (MOVE)

REFERRALS

"Hello, are you Mr.--------? My name is--------. A friend of yours, Mr. --------, suggested I drop by and see you. May I step in for a few moments?" (MOVE)

• • • •

"Mr.--------, my name is-------- with Standard Life and Accident Insurance Company. I have a card mailed to us by one of our policyholders. (HAND CARD TO PROSPECT) Evidently one of your friends. May I come in for a few minutes?"

(IF HE OBJECTS)
"This will only take a few minutes, Mr. Prospect. I'm sure you'll find it interesting. At least, one of your friends thinks you will." (MOVE)

• • • •

"Hello. Mr.--------? My name is ------ with Standard Life and Accident Insurance Company. Your friend (or cousin, brother, etc.), Mr.------, is one of our policyholders. He suggested I stop by and tell you about a new (DESCRIBE PLAN) and to see if you folks could qualify for it. They certainly think a lot of you. May I step in for a few minutes?" (MOVE)

NEIGHBORHOOD APPROACH

Wherever you call, there's always a house next door or across the street—even if it's a mile up the road. If you're calling on a mail lead, it is very likely that every house in the area received the same mailing. Many of these people meant to return the card. But they put it off, the card was lost, accidentally thrown away or torn up by a child. These people will welcome your call. If you're calling on a policyowner, you can bet their neighbors know they carry insurance with Standard Life. Our customers are our best boosters and their "word of mouth advertising" is a big help in landing new ones. In either instance, use this approach.

• • • •

"Mr.---------. My name is-------- with Standard Life and Accident Insurance Company. I just called on one of our policyowners, your neighbors, the-----s (OR) I just called on one of your neighbors, Mr.---------. He had returned a card asking for information about our (DESCRIBE PLAN). While I was in the neighborhood, I thought I'd stop in and meet you folks and find out if you have coverage with our company. (IF NOT, ASK WITH A SMILE:) Just how long have you been without insurance protection? I'd like to show you what all you're entitled to with this new plan—and see if you could qualify too. May I step in for a minute?" (MOVE)

LEAD CARDS

Lead cards, clipped from a magazine or returned from a mailing, are one of the most valuable sources of new business. The person has indicated their interest and it's been our experience that one out of two cards can be converted into sales. One important thing to remember: *never* telephone ahead for an appointment. Many people when confronted by a salesman are instinctively reluctant to carry their interest any further. It is easy to rebuff a telephone call. . .but not a personal appearance at their door.

"Hello. Are you Mr.________? My name is__________with Standard Life and Accident Insurance Company. We received your request for more information on our (DESCRIBE PLAN) and I'm here to give you that information and answer your questions. May I come in?" (MOVE)

(IF THE PROSPECT OBJECTS TO A PERSONAL CALL)

"We always extend the courtesy of a personal call to anyone who shows enough interest to write in. If I could just step in for a few minutes." (MOVE)

DOOR OPENERS

Following is a list of questions and statements that can be used singularly or in various combinations. They are designed to get the conversation started, to peak the prospect's curiosity and help you through the door. Memorize each of these. Start a "mental file" of these door openers that you can pull out and use any time the situation warrants.

- *"Who do you folks carry your hospital insurance with?"*
- *"Why did you let the policy lapse?"*
- *"How many are there in your immediate family?"*
- *"Are all of you in good health?"*
- *"Have any of you ever had heart trouble, high blood pressure, diabetes, cancer or any serious operations?"*
- *"Do you know the hospital room rates in this area?"*
- *(IF PROSPECT CARRIES INSURANCE, COMPLIMENT HIM ON HIS FORESIGHT; THEN BEGIN ASKING QUESTIONS ABOUT THE EXTENT OF COVERAGE, SEEKING A WEAKNESS.)*
- *"How much does your present plan pay for daily hospital room charges?"*
- *"Most people we talk to carry about half as much coverage as they need."*
- *"Have you ever had to use all the benefits of your present coverage?"*
- *"Did it pay all the bills?"*
- *"How much does your present plan pay for miscellaneous expenses?"*
- *"Is this amount allocated—earmarked?"*
- *"When did you first enroll in this plan?"*
- *"Does it pay in addition to Workmen's Compensation and other insurance?"*
- *"What does it pay for surgery?"*
- *"If you don't mind my asking, what does your present plan cost you a year?"*
- *"Does your plan pay you once you leave the hospital and are recuperating here at home?"*
- *(WHERE APPROPRIATE) "Is your present plan guaranteed renewable?"*
- *"This is extremely comprehensive and valuable coverage, Mr. Prospect. A number of people in this area now own this protection. In fact, you might know some of them." (LIST NAMES OF LOCAL POLICYOWNERS)*
- *"You never know when an accident or serious illness will strike. Only recently we have paid several large claims in this area." (LIST NAMES AND AMOUNT OF CLAIMS)*
- *"I'm sure you've known of families that have nearly spent their entire life savings on hospital and medical bills."*

- *"Perhaps you know, Mr.________, who had a serious (TYPE OF ACCIDENT) accident just a week or so ago."*

SETTING APPOINTMENTS

The first step in setting an appointment is to qualify the prospect. 1) Does he need the coverage? 2) Can he qualify? 3) Can he afford it? Frankly, don't waste your valuable time on people who do not meet these three qualifications.

In setting up an appointment, don't tip your hand in advance. Don't try to sell the policy on the doorstep. Tell the prospect only enough to arouse their interest. Take it one step at a time.

Furthermore, don't give your prospect an opportunity to say "no." Ask only questions that can be answered "yes." Or questions that give them a choice of two or three affirmative answers: "Would it be better if I stopped back before or after dinner?" Other questions include:

- *"Where does your husband work?"*
- *"What time does your husband get home from work?"*
- *"Then you will be through with your evening meal around 5:30. Right?"*
- *"Then you'll both be here for awhile after that, won't you?"*
- *"I'll stop back by around 5:45 and go over this with you and your husband."*

OVERCOMING INITIAL OBJECTIONS

Occasionally, there is a hard nut to crack. While he may have need and be interested in your offer, he can muster up a whole bagfull of reasons why he can't visit right now—or tonight. The persistent salesman has his own bagfull of answers. Here are a few.

"I'M BUSY NOW. I DON'T HAVE TIME TO SPARE."

"That's quite alright. I would prefer to talk with both you and your husband (wife) anyway. That way you can both hear about the plan at the same time and have an opportunity to discuss it together. What time would be most convenient for you folks—_______or_______?"

• • • •

"I DON'T TALK TO SALESMEN."

"Thanks for the compliment. My boss keeps telling me I'm a terrible salesman. Actually, Mr. Prospect, I'm a Company Representative. We're having a county-wide enrollment for residents of this area and we're pledged to explain this plan to everyone. It will just take a few minutes. May I come in?"

• • • •

"JUST LEAVE SOME LITERATURE AND I'LL LOOK IT OVER WHEN I GET THE TIME."

"Mr. Prospect, Standard Life offers tailored protection. I'm sure you realize I couldn't just leave literature. We need to discuss your particular needs and develop a plan best suited for you. And, of course, you're going to have some questions. That's another reason I'm here. To answer your questions and clear up any confusion. May I come in?"

• • • •

"WE'RE SIMPLY NOT INTERESTED IN BUYING ANYTHING TODAY."

"Of course not, because you haven't had the opportunity to learn what we are offering. You see, we're pledged to contact everyone in this area to explain this plan. And that's my only job. You are under no obligation to buy a thing. After you've listened to a full explanation of the plan, then you can determine in your own mind whether you're interested. Perhaps you're busy now. Would you prefer that I come back this evening?"

[redacted]

"YOU'RE JUST WASTING YOUR TIME, MISTER. WE DON'T BELIEVE IN INSURANCE."

"Let me ask you a question. Do you carry a spare tire in your car? (AFTER AFFIRMATIVE ANSWER) That's insurance! Hospital insurance is the same thing. You need it 'just in case'—just in case some illness or accident strikes a member of your family. In fact, in one out of two families, someone is hospitalized every year. It will just take a few minutes to explain this plan. And, of course, you're under no obligation. May I come in?"

• • • •

"I DON'T THINK I'D BE INTERESTED. I'VE NEVER BEEN SICK A DAY IN MY LIFE."

"You've been very fortunate. In fact, it's possible, that had you ever suffered a serious illness, you couldn't qualify for this plan. You have to be in acceptable health to own this plan. So really, now's the time to take advantage of this offer—while your health permits. Once your health fails you might not be able to qualify. There are a lot of people right here in (NAME CITY OR COUNTY) who would give anything to own this protection. But they waited too long. I'm sure you don't want the same thing to happen to you. May I come in?"

• • • •

"I'M SORRY. BUT WE DON'T HAVE MONEY NOW FOR INSURANCE."

"Actually, this plan is very inexpensive. Look at it this way: if your doctor told you one of your children needed an emergency operation, you wouldn't say 'No, we don't have any money now for an operation' would you? Of course not. If I can just step in for a minute, I will show you how reasonable our plan really is."

• • • •

"WE SAVE OUR MONEY TO PAY THE BILLS."

"You can only use your savings once. This plan can be used over and over again. In fact, the interest on your savings would pay for a real good hospital plan. If you have an illness or an accident and took $800 from your savings account, you would lose this interest for the rest of your life. However, with our plan, since it is guaranteed renewable (WHERE APPROPRIATE) you can use it for the rest of your life, regardless of your age or health. You'll see when I explain the plan. May I come in?"

• • • •

"EVEN IF I COULD QUALIFY, IT SEEMS TO ME THAT MOST OF THESE PLANS JUST DON'T PAY ENOUGH."

"I couldn't agree with you more. Too many hospital insurance plans pay only minimum benefits. However, I think after you see our plan, you'll agree that we more than cover most of the costs. And as far as claims are concerned, last year Standard Life paid over $15 million in claims. There aren't many companies that can match that. In fact, we just recently paid a sizeable claim to a (NAME OF CLAIMANT) right here in (CITY/COUNTY NAME). Perhaps you know him. No, our policyowners certainly get their money's worth. The benefits are very generous, as you'll see. May I come in?"

• • • •

"I'M SORRY, BUT I JUST BOUGHT HOSPITAL AND MEDICAL INSURANCE."

"That's fine. I'm glad to know you recognize the importance of owning insurance protection. However, there are all types of plans. Some are very complete. Others are not. I'd like to show you our plan. You'll find it very complete—and very reasonable too. It probably covers some areas that your present plan fails to cover. You may find you'll want to broaden your protection. You really owe it to yourself and your family to examine

what we have to offer. And, of course, there's no obligation. May I come in?"

• • • •

"I'M SORRY, BUT WE BELONG TO A GROUP INSURANCE PROGRAM."

"That's fine. Most group programs are very good while you're working. But if you (your husband) should change jobs, retire or be out of his job due to illness or injury, this coverage could be terminated. Of course, your husband (you) is probably not thinking of leaving his job, but you never know. If serious illness or injury should strike, you'd suddenly find yourself unable to qualify for any insurance. Besides, many group programs are somewhat incomplete. Our plan could be a very important supplement, because the benefits are paid in addition to any group plan and these cash benefits are paid direct to you. It will only take a few minutes to explain our plan. May I come in?"

• • • •

"WE'VE CARRIED OUR PLAN FOR A LONG TIME. WE HAVE SO MUCH INVESTED IN IT THAT I WOULDN'T WANT TO DROP IT NOW."

"If you've carried it for a long time, then that's all the more reason to investigate a change. The chances are your protection is very inadequate to meet today's high cost of medical aid and hospitalization. You should bring your coverage up-to-date to meet what doctors and hospitals charge now. I'm sure you don't carry the same fire insurance policy on your home today that you did 15 years ago. Costs have risen and your home is probably worth more today. Yes, your fire insurnnce protection has increased to cover the value of your home today. You should do the same thing with your hospital insurance. In fact, your chance of sickness or injury striking is about 40 times greater than the chance of fire. May I step in and explain just how this plan works?"

"MISTER, IF I BUY INSURANCE, I'LL GET IT FROM A LOCAL MAN."

"Frankly, your local agent must not be too interested in you or he would have contacted you about this plan by now. Actually, you should buy your fire and auto insurance from a local agent. But your hospital insurance should come direct from the company. Besides that, I'm as near as your phone. It will just take a few minutes to explain our plan. May I come in?"

• • • •

"I DIDN'T SEE ANY ANNOUNCEMENT ABOUT YOUR PLAN IN THE PAPER."

"I'm sorry you overlooked it. I have a copy from Monday's paper. May I step in a minute and I'll show it to you."

• • • •

"I'D LIKE TO HEAR ABOUT YOUR PLAN, BUT I'M NOT ABLE TO GET INSURANCE."

"Standard Life now offers insurance for a great many people previously considered uninsurable. Chances are very good that you could qualify for one of these plans. Besides, even though you might not be able to qualify yourself, that's all the more reason you should inquire for the rest of your family. May I come in?"

• • • •

"I'M SORRY MISTER. BUT I CARRIED INSURANCE ONCE AND GOT CANCELLED."

"I'm sorry to hear that. I doubt if it was our company. All of our plans are guaranteed renewable—they can't be cancelled. Besides, Standard Life now offers a number of plans for people previously considered uninsurable. Even though you've been rejected by one company, chances are very good there's a Standard Life plan for you. May I come in?"

"IS YOUR INSURANCE GUARANTEED RENEWABLE?"

"Yes, sir! Most all our plans are guaranteed renewable. In fact, with Standard Life, you own a plan. You don't rent it. May I come in?"

3. GAINING YOUR PROSPECTS CONFIDENCE

Take the first five or ten minutes of your interview to get acquainted with your prospect. Find out as much as possible about his business or occupation, his hobbies and other interests. If this is a referral call, discuss the person who referred you to this prospect.

Also tell the prospect something about yourself and Standard Life. If he doubts the integrity of you or the company, all the talking in the world won't close the sale. Some of our agents have even put together a notebook containing photos of their family, reprints of awards and commendations and other personal items that indicate to the prospect that they are family men just like everybody else. Honest, hard working and worthy of trust.

This early informal conversation is vital. It helps lower the prospect's barriers. It removes any feelings he might hold that you are a fast operator or the type of salesman he'll never see again. It reduces his suspicions and puts him at ease.

4. SELLING THE *NEED*

Most people recognize the need for insurance. If not, then you must sell them on this need. The "spare tire" analogy is a good one.

Most people have taken some step to fill this need. However, in many cases they have not taken the right step or a complete step.

It is up to you, in the course of your discussion, to determine exactly what the family needs and sell this need. Are they vulnerable to excessive costs in one area of their present coverage? Is their plan out of step with today's medical costs? Is the plan renewable at the option of the company? Are the premium costs in line with their ability to pay? Does the senior citizen realize that Medicare doesn't pay all the bills?

Everyone needs insurance. Most everyone recognizes this need to varying degrees. It is up to you to establish their needs and sell them on the wisdom of filling these needs.

5. YOUR PRESENTATION

We have already covered most of the bases in the preceding section on Product Knowledge. The primary objective of a good presentation is to tell the product story in the most meaningful manner and the fewest words. By memorizing a written presentation these objectives are accomplished. You know precisely what you're going to say. There is no hesitancy, no uncertainty, no misunderstandings, no misrepresentations. Every point is covered, every benefit clearly explained. Combined with your own enthusiasm, conviction and authority, your presentation will lead easily and cleanly into the final step of selling.

6. THE CLOSE

If you have closely followed the methods described in the first five steps of selling, you will have little trouble completing the sale.

In your arsenal of closing ammunition there are five basic methods that have proved successful. In most cases, you should use them in the order they are presented here. If the first one fails, move on to the second, and so forth.

The Assumed Close. When you have completed your presentation, immediately take out an application and start writing. Do not stop until the prospect either stops you or signs on the dotted line. As you ask the questions on the application, look the prospect straight in the eye until he answers them. If he should stop you, try to persuade him to allow you to complete the application. And again, seek his signature on completion. If he is still reluctant, try the "Six of one or half a dozen of the other" close.

"Mr. Prospect, I talk to a lot of people in the course of my work. And it's usually about six of one or half a dozen of the other as to what they should do. But in your case, there is absolutely no doubt (STRIKE THE TABLE FOR EMPHASIS) what you should do. (RESTATE A FEW OF THE REASONS WHY THE FAMILY NEEDS THE COVERAGE) Do not pass this up!" (HAND HIM THE PEN)

If he continues to object, move on to the second close.

The "Why?" Close. This is a simple question: "Why don't you want to start this plan, Mr. Prospect?" It is very important that you do not attempt to answer this question for him. Let him state his reasons himself. Often when he actually puts his reasons into words, they suddenly become very weak and feeble in his own mind, and it is a simple job to agree with the objections and quickly dismiss them. If the objections are sound, try to counteract them with one of the "Rebuttals" listed on the following pages. If this fails, proceed to the next close.

The Fear Close. Here you point out what can happen to him and his family financially should he be without this coverage and faced with costly medical bills. Remind him of the millions of dollars spent each year for hospital bills; how one person out of every two families is hospitalized each year; how the cost of just one hospitalization will more than cover the premium for an entire year. The "Salary Close" can also be used in this instance.

"Then as I understand it, Mr. Prospect, the only reason we can't get together now is that you feel (RESTATE HIS OBJECTION). Is that right? (AFFIRMATIVE ANSWER) I can understand your feeling. However, let's look at it this way. Suppose you were looking for a job. You walk into one place of business and you're offered $150 a week. (USE HIS ACTUAL SALARY IF POSSIBLE) The boss tells you that he will pay you this $150 a week as long as you are able to work. However, when you're sick or injured, he won't be able to pay you anything because he would have to hire a replacement. That's about the way it is on your present job, isn't it? Then suppose you walked down the street and into a second place. This one offered you a job with the same hours and duties. However, here the boss said he'd pay you $______a week. ($150 OR THE PROSPECT'S PRESENT SALARY, LESS THE WEEKLY COST OF THIS PLAN) But, for this $____less per week, he would continue to pay you while you were off the job, unable to work. Now in all honesty, all other things equal, which job would you take? (AFTER HE CHOOSES SECOND ALTERNATIVE, ASK THE PROSPECT "WHY?" AND LET HIM CLOSE THE SALE HIMSELF) And that is exactly the choice you have now...and a choice you can make only as long as you remain in good health. So let's go ahead and put this protection to work for you. (MOVE IN WITH PEN AND APPLICATION) If you'll just write your name here, and be sure to include your middle initial."

The Pride Close. Many people want to keep up with the Joneses. Name some of the local people, the prospect's own neighbors if possible, who own this coverage.

The "Need-Like-Cost" Close. This is admittedly a pressure close. But, one of the most effective closes you can use.

"Mr. Prospect, during our lifetime, we buy many things—furniture, cars, a home, clothing and so forth. And we always buy or reject these things based on the answers to three questions we ask ourselves: Do I need it? Do I like it? Can I afford it? (AT THIS POINT, DRAW A BOX DIVIDED INTO THREE PARTS AND WRITE IN THE WORDS "NEED, LIKE, COST.")

NEED
LIKE
COST

Now, Mr. Prospect, let's look at this plan on that same basis. If you were disabled or in the hospital, would you need this money?" (WHEN HE ANSWERS "YES," PLACE A CHECK MARK BESIDE "NEED," AND CONTINUE) O.K. Do you like this plan and my company? (CHECK "LIKE") And finally, Mr. Prospect, can you afford it?" (CHECK "COST") (IF HE ANSWERS "NO" TO ANY QUESTION, THEN GIVE ONE OF THE FOLLOWING CLOSES: NEED—"THE FEAR CLOSE"; LIKE—THE CONFIDENCE CLOSE, RESTATING THE PRESTIGE OF STANDARD LIFE, INCLUDING THE RATING IN DUNNE'S REPORT; COST—"THE SALARY CLOSE.") (IF HE ANSWERS "YES" TO ALL THREE, THEN IMMEDIATELY ASK FOR HIS SIGNATURE.)

REBUFFING CLOSING OBJECTIONS.

Rebuttals are designed to create a meeting of the minds. They are not designed to win an argument or to prove you're right and your prospect is wrong. Rebuttals are used to lead your prospect around to your lines of reasoning, to a meeting of the minds, with the end result being A Sale.

Give your rebuttals in a "positive" manner. It is often not so much what you say, as the way you say it that determines the effectiveness of a rebuttal. Watch your prospect's reactions. This will indicate how effective your rebuttals are.

Try *not* to give rebuttals during your actual sales presentation. Stall your prospect, if possible: "That's a good point. I'm coming to it in just a minute." or "I'll answer that in just a minute, if you don't mind. I wanted to finish making this point." One of your objectives is to make your presentation without interruption. Chances are good that by putting him off, he'll forget his objection anyway.

Good rebuttals enable you to take command of the situation. If you can't keep this command then you should leave. However, understanding the construction of good rebuttals will enable you to maintain command and handle most any objection. Study the following five points outlining and illustrating the construction of a rebuttal. They will serve you well.

1. **Disarming your prospect.**
    - *"I'm glad to hear that."*
    - *"I'm glad you asked that."*
    - *"That's just why you need this protection."*
2. **A logical explanation.**
    - *"Nearly everyone I sell carries other insurance."*
    - *"There are only three things to consider: could you use the money?; do you like the plan and my company?; and can you afford it?"*

- *"We have no contract with life. Regardless of how careful you and I may be, we never know what the other guy is going to do."*

3. **An agreeable, positive statement.**
   - *"That's how we do it."*
   - *"I think you should take it."*
   - *"I think it's worth 8-cents a day."*
4. **Ask an affirmative question.**
   - *"Isn't that true?"*
   - *"Don't you?"*
   - *"Do you see what I mean?"*
5. **The *punch* close.**
   - *"Let me write it for you then."*

Occasionally you're going to run into a tough customer that just will not be sold. Be a gracious loser. Relieve the tension by giving him a big smile and a "thanks just the same—I'll see you next time I'm this way." And leave immediately.

With the not-so-tough customer, who just needs one more push to overcome his objection, try one of these rebuttals.

"I NEED TO THINK IT OVER."

"The one thing you can't wait to buy when you need it is insurance. You're in good health now and now is the time to take advantage of this program—while your health permits you to qualify. After all, if your doctor told you or some member of your family you must enter the hospital, you wouldn't tell him you had to think it over. This is the same thing. Now, how would you like to handle your first premium? By cash or check?"

• • • •

"I'LL LET YOU KNOW WHEN I DECIDE."

"Your decision is really an easy one. This is a simple, practical plan. You cannot decide when you're going to be sick or injured. But you can prepare now for those troubles. Now, you can pay your premiums on a yearly basis, twice a year, quarterly or monthly. Which would be most convenient for you?"

• • • •

"NOT NOW. COME BACK BY THE NEXT TIME YOU'RE IN THIS AREA."

"I'll make you a deal. If you can guarantee to me that your health will not change in the meantime, that you will have no sickness or accidents in your family, I'll be back. Otherwise, you need to write your full name right here."

• • • •

"I JUST DON'T BUY ANYTHING ON THE FIRST CALL."

"The only thing that could possibly change between now and the next time I call would be your health. And then you might not be able to qualify. Actually, Mr. Prospect, I think I must have failed to clearly explain this plan, because nearly everyone we talk to is ready to sign up. What have I left out? What are you unsure of?"

• • • •

"I'LL SEND THE APPLICATION TO YOU WITH THE MONEY ON PAYDAY."

"I'm afraid that's not possible. You see, the information on this application must be taken by a duly licensed company representative in the presence of the applicant. The reason for this is that we are taking your application on the basis of your health as it is today. It must be dated and signed by both of us. So if you'll just write your full name here, we'll get this protection started right away."

• • • •

"I WANT TO TALK TO MY LAWYER FIRST."

"That's a very wise idea. When your policy is delivered it will have your name on it and it will tell you exactly how much you will receive under any and all circumstances. That's the time to show it to your lawyer. Now, how would you prefer to handle your premiums? By the month,

every three months, twice a year or yearly?"

• • • •

"I WANT TO SEE WHAT ANOTHER INSURANCE COMPANY HAS TO OFFER FIRST."

"You have no protection now. The longer you wait the longer you go without protection. You apparently recognize the need for this kind of protection or you wouldn't be interested in checking with another company. Our plan is available to you now. It provides you with the protection you need—and at a cost you can afford. Wait and you're simply increasing your chances that illness or injury could prevent you from ever qualifying again. If you'll just write your full name here, we'll see that this protection gets started right away."

• • • •

"WE HAVE A FRIEND WHO SELLS THIS KIND OF INSURANCE."

"You apparently didn't think he had much to offer or you would have bought it by now. No, when it comes to investing in medical insurance, you're interested in buying the best possible protection for your family. Not in buying coverage just because it's offered by a friend. Now, how would you like to handle your first premium? By check or cash?"

• • • •

"WE'VE GOTTEN ALONG WITHOUT IT THIS LONG. WE CAN GET ALONG WITHOUT IT A LITTLE LONGER."

"Everyday, you and I get a little older. We're like cars. The more miles that are put on us, the closer we come to needing repairs. While you've been extremely fortunate so far, each day brings you closer to possible sickness. So, just write your full name right here and we'll make sure you're well protected when this does occur."

"I DON'T NEED THIS. I CAN AFFORD TO PAY MY OWN BILLS."

"You're very fortunate. However, I've seen many folks lose their entire life savings due to a prolonged illness. Remember, your savings can only be used once. If you invest in this fine plan, however, it will be there to take care of you and your family over and over again. It's just good business. Now, you can handle this first premium either by check or cash. Which would be most convenient for you?"

• • • •

"IT SEEMS LIKE A GOOD PLAN. BUT I JUST CAN'T AFFORD IT."

"You know, Mr. Prospect, there are about 180 million Americans right now who feel they cannot afford not to have this type of protection. When you realize how little it costs compared to your other expense and compared to the generous benefits that could save your family from financial ruin, I think you'll see that you too cannot afford to be without it. Of course, we offer four methods of payment. Perhaps the monthly payment method would be most convenient for you. Or you can pay every three months, twice a year or once a year. Which method do you prefer?"

• • • •

"I WAS CHEATED ONCE BY ANOTHER COMPANY. NEVER AGAIN!"

"I'm sorry to hear that. Of course, you'll find the same thing in any business. There's always a few rotten apples. As far as our company is concerned, Mr. Prospect, I can give you the names of several people in this area who can vouch for our reliability and for our claim service. Now, if you'll just write your full name here, we'll see that you receive the kind of service you would expect from a reputable company like Standard Life."

"I'M A VETERAN. I CAN GO TO A VETERAN'S HOSPITAL ANY TIME I NEED MEDICAL ATTENTION."

"I'm sure in case of emergency you would want to use your local doctor and your local hospital rather than drive all the way to (NAME OF CITY WHERE NEAREST VET HOSPITAL IS LOCATED). You may not realize it, but veteran's hospitals are mostly for chronic and long drawn out illnesses. And admittance arrangements usually have to be made well in advance. Besides, only you are a veteran—not your wife and children. No, when you're sick or injured you want immediate care. And that's what we're offering. So if you'll just write your full name here, we'll see that your protection begins immediately."

• • • •

"I'VE NEVER HEARD OF STANDARD LIFE."

"I'm sorry you've missed our advertisements. Here's a copy of one that appeared in a recent issue of ------. Standard Life is actually one of the largest insurance companies in the nation. We rank in the top 10-percent of all companies nationwide. We're very well known right here in your own community too. Here is a list of some of your neighbors who carry insurance with us. I know they would be glad to vouch for us. If you'll just write your full name here, we'll get you started and you can find out for yourself what a fine company we are to do business with."

• • • •

"IS THAT AN APPLICATION YOU'RE FILLING OUT?"

"No, this is a medical questionnaire. It becomes an application when you write your name here at the botton."

• • • •

"WHY DON'T YOU HAVE A POLICY THAT PAYS ALL THE COSTS?"

"For one reason, doctor and hospital costs vary so much, it would be nearly impossible to keep up with all of them. And a second very important reason, the premium cost for such coverage would be so high that no one could afford it. This is the most complete protection you can own for the money. And all it takes to get started is for you to write your full name here."

• • • •

"HOW DO I KNOW YOU PAY YOUR CLAIMS?"

"Standard Life has one of the finest reputations in the insurance industry for claims payments. In fact, I have a list here of some of the people in this area who have received money from us. You may be acquainted with some of them. They can vouch for our reputation. Now, how would you like to handle your first premium? By cash or check?"

• • • •

"I CAN'T AFFORD IT."

"Mr. Prospect, maybe we had better look again at the way hospital costs have climbed over the past few years. You can't afford not to have this protection. And you don't have to pay your premiums annually. Maybe every three months would be better for you."

• • • •

"I ALREADY HAVE INSURANCE THAT COVERS ME PRETTY WELL"

"That's true, you do have a fine program. However, no policy can keep up with the rising medical costs for very long, and that's exactly why my company came out with this policy; to give you the opportunity to keep your coverage up to date. That's really important today, isn't it?"

• • • •

"HOW DO I KNOW I CAN QUALIFY?"

(Field Issue) *"I am prepared to issue your policy right now. There are no health questions to answer."* (Home Office Issue) *"We can't know for sure today, but let me ask you these few health questions and see how it looks on paper."*

"I DON'T LIKE THAT THREE DAY ELIMINATION PERIOD FOR SICKNESS."

"This is just a way of keeping the cost of your protection down. And keep in mind that this is supplemental insurance. What you have now will take care of you for the first three days without too much hardship. This policy is designed to pay for more extended periods of hospitalization.

• • • •

"I HAVE NEVER BEEN SICK A DAY IN MY LIFE."

"I hope you never are! But you know that many people enter the hospital each day. Most of them probably felt just like you. And no matter how healthy we are we're still subject to an unexpected injury, aren't we?"

"IS STANDARD LIFE A GOOD COMPANY?"

"Yes, sir! Standard Life is an old line, legal reserve stock company with almost a billion dollars of life insurance in force and over $100 million in assets. You can be sure with Standard Life. Doesn't this sound like the kind of company you would like to be associated with?"

Item 4

Consumers Union
Publisher of Consumer Reports

May 21, 1990

Senator David Pryor
Chairman
Special Committee on Aging
United States Senate
SR-267
Washington, DC 20510

Dear Senator Pryor:

Attached is a copy of Consumers Union's report **Health Insurance Counseling Programs for Senior Citizens: A Survey**. We are submitting it for your consideration as part of the hearing record from the Special Committee on Aging's March 7, 1990 hearing on **Medigap Insurance**.

Consumers Union's witness at the hearing, John Hildreth, referred to this survey, which was then in progress. The final report confirms the early findings: senior citizen health insurance counseling programs are cost-effective sources of objective advice. Through reliance on volunteer networks and community organizations, the programs have provided thousands of senior citizens assistance they need to reduce wasteful duplicative coverage and identify insurance policies that are appropriate for them.

The survey underscores the urgency of Congressional enactment of the Health Insurance Counseling and Assistance Act of 1990 (S.2189). We look forward to working with you and your staff to achieve this goal in the near future.

Sincerely,

Gail Shearer

Linda Lipsen
Legislative Counsel

Gail Shearer
Manager, Policy Analysis

Enclosure

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HEALTH INSURANCE COUNSELING PROGRAMS FOR SENIOR CITIZENS:

A SURVEY

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PREFACE

This survey shows that state programs to counsel senior citizens about health insurance work well. They help senior citizens to purchase the coverage they need, and often lead to substantial savings when unnecessary policies are identified and dropped. The programs provide a source of objective advice. Without such advice, senior citizens are typically at the mercy of whatever agent knocks at their door or whatever sales material arrives in their mailbox.

We hope that the report will encourage additional states to establish counseling programs. In addition, we believe it underscores the urgency of Congressional enactment of the Health Insurance Counseling and Assistance Act of 1990 (S.2189) which was recently introduced by Senator David Pryor.

The report was written by Mary Griffin, a graduate of Temple University Law School and an intern with Consumers Union. She conducted the telephone survey while participating in the clinical law program at the George Washington National Law Center, as part of her coursework for her L.L.M. degree.

We appreciate the help that we received from all of the programs included in the survey. Their cooperation made this report possible.

Gail Shearer
Manager, Policy Analysis
Consumers Union

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Definition of Terms

Medicare: Medicare Part A and Part B insurance coverage
Medigap: Medicare supplemental insurance policies
LTC: Long Term Care policies
HMOs: Health Maintenance Organizations
PPOs: Preferred Provider Organizations
AAA: Area Agency on Aging
AARP: American Association of Retired Persons
MAP: Medicare Assistance Program
RSVP: Retired Senior Volunteer Program

HEALTH INSURANCE COUNSELING PROGRAMS
FOR SENIOR CITIZENS: A SURVEY

KEY FINDINGS

Choosing health insurance can be a confusing and frustrating task for any consumer. For senior citizens, the task is especially challenging. Filling out complicated forms, deciding which options to choose, figuring out which costs are reimbursable, and understanding which benefits are provided may be overwhelming hurdles for them. Flooded with calls and inquiries from senior citizens about their health insurance, a number of states have responded by providing face-to-face, individual health insurance counseling programs. The programs have received praise from legislators, the state agencies sponsoring the programs, the counselors, and, most importantly, the seniors who have received invaluable assistance.

With relatively low budgets, the counseling programs are extremely successful at reaching and educating thousands of senior citizens. Counseling not only helps seniors understand health insurance but it saves them money. The Wisconsin program, for example, estimates that it saves seniors nine dollars for every dollar spent on the program; California's HICAP program reports a savings of two dollars for every program dollar. The cost-effectiveness of the programs has prompted states to expand in a variety of ways: by setting up programs in more areas, by providing more personnel to oversee and administer the program, by creating more sources of information to ensure that more seniors are reached, or by giving more training to counselors.

Consumers Union conducted a survey of the twelve states that have implemented counseling programs. In addition, we contacted ten other states to find out how they are responding to the needs of senior citizens with regard to obtaining information and assistance with their health insurance. Our findings from the survey demonstrate both the need for counseling programs and the success achieved by those states with counseling programs in place.

Key findings include:

1. **Cost-Effectiveness of the Programs:** As noted above, the programs in California and Wisconsin estimate that dollar savings to senior citizens far exceed the program costs. Most counseling programs operate on budgets of $200,000 or less. Although all programs report the need for more funds, the current budgets have

enabled the states to provide face-to-face, individual counseling to thousands of seniors. In New Jersey, for example, 10,000 seniors were served in 1989, up from 2,000 in 1987, on a $100,000 budget. The value of each program dollar is high because most of the programs use volunteers and the local administration of the programs often is provided on a pro bono basis by organizations.

2. **State Sponsorship of Programs:** All of the programs are sponsored by either the state's Office on Aging or the Department of Insurance in the particular state. Employees of the agencies typically administer the program on a state level and have the resources of the agency available to them. The state provides personnel for training and training materials along with consumer guides, fact sheets, and updated information. State sponsorship enhances the program's ability to disseminate current and often changing information about federal and state assistance programs and insurance policies and regulations. As one program director noted, seniors are often skeptical about the source and reliability of information provided to them but they are relieved to obtain objective, reliable, and up-to-date information from the state through trained counselors.

3. **Volunteer Based Programs:** All except one of the programs are volunteer-based, relying on a network of organizations throughout the state to recruit and organize volunteers. Volunteers are required to participate in both the initial and ongoing training sessions made available by the state sponsoring agency. Volunteers are provided with comprehensive training manuals and periodic updates and are expected to be knowledgeable about the various forms of insurance covered by the program or to seek assistance from the local or state coordinator in situations in which the volunteer is not able to provide a correct response to a client's inquiry. Volunteers are required to fill out report forms for every counseling session and must keep client information confidential. The programs take pride in providing thoroughly educated and knowledgeable counselors. Counselors not only conduct individual counseling sessions but also provide group seminars in some states. An example of the commitment these programs have in providing highly trained counselors is in Massachusetts, where the counselors are given a take-home exam. The answers to the exam questions are discussed at the last session of the initial training.

4. **Reliance on Local, Community Based Organizations:** While the workforce for the counseling programs is primarily volunteer,

local organizations provide the infrastructure for the volunteer efforts, by providing staff to administer the program on a local level and often the office space for the counseling. Some programs provide grants from the state to the local organization to fund the positions to administer the program but most of the programs rely on the donated services of the local organization. There is ongoing contact between the state personnel and the local coordinators of the program to ensure the flow of information and to maintain the status of the program. Most programs are flexible in their approach and allow the local organizations to conform the program to address the particular needs of seniors in their area.

5. **Wide Range of Assistance:** All programs provide both individual one-on-one counseling and group education in the form of seminars or public speaking. The programs vary in terms of the types of assistance provided to seniors and the subject matter covered but all programs cover, at a minimum, Medicare Part A and Part B, Medicare supplemental insurance, and long term care insurance policies. The majority of the states provide assistance in the filling out of forms; filing claims and appeals; and in guiding seniors through the insurance bureaucracy to ensure clients receive all benefits to which they are entitled. If a service is not provided by the program, all the programs will refer the client to the appropriate organization or agency, including the consumer division of the state's Insurance Department. Most programs provide counselors with a directory of referral organizations. Legal assistance is a component of some of the programs. In California, for example, the legal representation component has been extremely successful, increasing from 1,041 legal services client contacts in 1986-87 to 2,391 in 1987-88. Through legal services assistance, senior citizens are able to obtain representation at administrative hearings and on appeals from adverse agency actions, and gain access to the court system in the form of individual or class action suits.

6. **Benefits to Senior Citizens:** Benefits to senior citizens of states with counseling programs are real. The following are just a few of the examples of actual cases in which senior citizens are assisted through counseling:

-- In California, HICAP assisted a Spanish speaking couple who had been pressured into joining a Health Maintenance Organization (HMO) but were told by the aggressive representative that they could cancel by phone. The day after they signed up, the couple called the HMO to cancel. The couple continued to use their non-HMO providers but when Medicare denied their claims, they realized that the HMO had not cancelled their membership. By the time the HMO finally allowed the couple to disenroll, they were liable for over $26,000 worth of unpaid claims. With the assistance of a bilingual HICAP Counselor, the couple appealed the claims and the HMO ended up paying the $26,000 in out-of-plan claims.

-- After sifting through a shopping bag full of bills and papers, the SHICP counselor in Maryland coordinated the bills and statements and cleared up the accounts. During the counseling, it was discovered that the woman had duplicative coverage. She was advised to keep only one policy resulting in a savings of almost $2,000 annually.

-- Program volunteers in Idaho referred a man to the insurance department's investigator's office. The man owned duplicative policies and was able to obtain a refund of $11,000 with the assistance of the investigator.

-- In New Jersey, a client was faced with a court action brought by a surgeon. With the assistance of a counselor, the client successfully defended the small claims action avoiding a $1,200 judgment.

-- A local HICAP project in California was contacted by a client who had been sold a nursing home insurance policy by an agent from a well-known insurance agency. The agent had come to the client's house unannounced but displaying a card the client had mailed several months earlier to a "consumer alliance" group. The group, a front for an insurance agency, has been prohibited since then from mailing in California through a cease and desist order issued by the California Department of Insurance. At the time of the visit, however, the agent succeeded in pressuring the client into purchasing the nursing home policy: the agent would not leave until the client signed the check. She has an income of $1000 per month and savings of less than $7000. The agent left no information about the policy which cost $684 per year and would only cover the client for two years. Upon the suggestion of the HICAP volunteer, the client called the agent to obtain information on the policy and clarify the benefits. The agent was very rude to the woman when she made inquiries about the policy. Consequently, the client decided to stop payment on her check and to cancel the coverage with the assistance of a counselor.

Most of the programs are new but have become well known and popular among the senior populations in the states. Washington's program, begun in 1979, is the oldest. Ohio's program is the newest; its pilot program will begin in May of this year. Some of the states without programs are investigating the various programs to develop a model of their own. Senior citizen counseling programs are a low-budget, responsible way of helping senior citizens get more value from their health insurance dollars. We believe this survey shows that all states should establish them and that Congress should enact the Health Insurance Counseling and Assistance Act of 1990 (S.2189) which was introduced by Senator David Pryor.

SUMMARY OF STATE COUNSELING PROGRAMS

PROGRAM	SPONSOR/ DATE OF STARTUP	INFORMATION PROVIDED	ASSISTANCE PROVIDED	BUDGET/ SOURCE	STATE STAFF/ VOLUNTEERS	NUMBER SERVED ****	TOLL FREE NUMBER/ HOTLINE
California HICAP	Aging 1984 Legislation	Medicare, Medigap, HMOs, PPOs, H/I, H/H	Public education, counseling, legal assistance; Forms, Claims, Individual & Legislative Advocacy	$2.44m DOI	Staff: 7 V: 500+	45,000c 100,000g	
Idaho SHIBA	Insurance 1986	Medicare, Medigap, Medicaid, LTC, HHC	Public education, counseling: Forms, Referral	$119,000 DOI	Staff: 3 V: 275	3,000c	
Illinois SHIP	Insurance 1988	Medicare, Medigap, Medicaid, LTC, Retirement	Public education, counseling: Forms, Claims, Referrals	N/A DOI	Staff: 3 V: 400	1,000c	800-548-9034
Iowa PACT	Insurance 1990	Medicare, Medigap, Medicaid, LTC	Public education, counseling: Forms, Claims, Referral	N/A DOI	Staff: 1 V: N/A	N/A	
Maryland SHICP	Aging 1987	Medicare, Medigap, Medicaid, LTC, Social Security	Public education, counseling, legal assistance; Forms, Claims, Ind. Advocacy	$169,406 DOA	Staff: 1 pt V: 60	2,300c 5,640g	800-AGE-DIAL
Massachusetts SHINE	Aging 1986	Medicare, Medigap, LTC, HMOs, Gov't Employees, CC, Discharge laws, Retirement	Public education, counseling: Forms, Claims, Individual & Legislative Advocacy	N/A DOA	Staff: 4 V: 200	3,000c	
New Jersey SHIP	DCA* 1987	Medicare, Medigap, LTC, HMOs, Indemnity	Public education, counseling, Forms, Claims, Referrals	$100,000 DCA	Staff: 3 V: 250	10,000c	800-792 8820
New Mexico HIBAC	Aging 1988	Medicare, Medigap, LTC, SSI, State Assistance Programs	Public education, counseling, Forms, Claims, Referrals	$43,000 DOA	Staff: 1 V: 170	1,000c	800-432-2080
North Carolina SHIIP	Insurance 1986	Medicare, Medigap, LTC	Public education, counseling: Information and referral	$181,000 DOI	Staff: 5 V: 1500	3,000c	800-443-9354
Ohio Pilot Program	AG** 1990	Medicare, Medigap, Medicaid, LTC, Retirement, COBRA	Public education, counseling: Information and referral only	N/A	Staff: 1 V: N/A	N/A	
Washington SHIBA	Insurance 1979	Medicare, Medigap, LTC, other insurance as need arises	Public education, counseling: Forms, Information and Referral	N/A DOI	Staff: 4 V: 350-400	N/A	800-562-6900
Wisconsin Benefits Specialists	DHSS*** 1978	Medicare, Medigap, Medicaid, LTC, HMOs, any other insurance	Public education, counseling, legal assistance; Forms, Claims, Individual & Legislative Advocacy	$1.52m Fed/State	Staff: 55 only paid staff	38,500c	see Hotline
Hotline	Insur. & Board on Aging	Medigap, Medicare	Information over the phone and brochures				800-242-1060

* Department of Community Affairs, Division on Aging
** Attorney General's Office
*** Department of Health and Social Services, Bureau on Aging
**** Number represents most current year provided
c: counseled on an individual basis
g: educated by group seminar
CC: Continuing Care policies
COBRA: rights provided under the Consolidated Omnibus Budget Reconciliation Act
HHC: Home Health Care policies
H/I: Hospital Indemnity policies
HMO: Health Maintenance Organization
LTC: Long Term Care policies
PPO: Preferred Provider Organization

CALIFORNIA

1) PROGRAM

Health Insurance Counseling and Advocacy Program (HICAP) Program was established in 1984 and began service in late 1985.

2) SPONSORSHIP

a) California Department of Aging (CDA)

b) Legislation, passed in 1984, Welfare and Institutions Code, sec. 9750-9756, created program.

c) Legislation requires Department to provide:

- public education, counseling and legal representation to as many Medicare beneficiaries as possible
- annual report to the legislature on performance, expenditures, savings realized by the program
- grantees, or local projects, are given appropriations and have responsibility for carrying out the program's services

3) FUNDING

a) Source:

1. Funds come from the state Department of Insurance (DoI) fund. The funds are allocated to CDA which then distributes grants to local projects.

b) Amount and Distribution:

1. Budget for 1986-87 was $888,000; 1987-88 was $1,549,000; current budget is $2,666,000.
2. Most of the funds are distributed to local projects with the remainder allocated for state administrative personnel (including trainers) and costs.

4) ADMINISTRATION

a) State:

1. Department of Aging: HICAP program administered on state level via CDA. In 1988, HICAP had one Manager, one Clerical, three Program Operations Analysts, one Training Developer (split position), and one Clearinghouse Coordinator.
2. State administration's responsibilities are:
   a. General Operations: contracts, technical assistance, support functions, and quality control; monitoring.
   b. Clearinghouse function: producing and updating information.
   c. Training support: curriculum and training development.
   d. Publicity: coordinating uniform publicity efforts.
   e. Complaint monitoring: recent legislation requires DoI to develop (with CDA) interagency procedures for referring and investigating sales misrepresentations (AB 1121, ch.289, statutes of 1987).
   f. Insurance policy analysis: with the DoI.
   g. Management Information Systems (MIS): provide legislature and local grantees with information on current situation and future planning. Reporting requirements for local projects.

b) Local:

1. Local organizations or projects: HICAP provides grants to 24 local organizations to implement the program in various counties. Grants range from $40,000 to $400,000 depending upon the service area population. Agencies receiving grants vary from County Offices on Aging to Legal Centers. Most local grantees are Area Agencies on Aging (AAAs) or Senior Citizen organizations.

2. Local Program Managers: employees of grantees.

   - organize program on local level
   - manage and administer program
   - recruit volunteers
   - compile data and report to state level
   - liaison to state program
   - organize trainings
   - fiscal management of grant money

3. Volunteers:

   - attend initial and follow-up training
   - reporting requirements
   - referral of cases for legal assistance
   - participate in annual training
   - counsel at site or, in special circumstances, in beneficiary's home
   - assist with forms; understand forms and health insurance coverage
   - keep client information confidential

5) TRAINING OF VOLUNTEERS

a) Initial training:

- Medicare and health insurance policy analysis

b) Who trains:

- staff of HICAP and consultants/private contractors

c) Follow-up training:

- minimum of 12 hours ongoing each year
- regional training seminars
- monthly communications to update volunteers

d) Type of Counseling:

- one-on-one counseling
- group education and seminars provided

e) Materials provided:

- training manual (revised manual pending)
- comprehensive client referral listing
- newsletter (locally)
- brochures, pamphlets
- consumer guides

f) Number of volunteers:

- 1988-89: an average of 500+ volunteers. In 1990, all HICAP Counselors must be registered by the State Office (CDA).

6) SCOPE

a) Coverage:

- Medicare, Medigap, LTC, HMOs, PPOs, indemnity policies, and hospital marketing plans
- community education, counseling and informal advocacy, and legal services
- counseling must be free of charge and objective

b) Public relations:

- local and state: brochures, consumer guides, and publications

c) Advocacy is part of program.

d) Geographic area covered:

- Medicare beneficiaries in all 58 counties of the state are divided into 24 HICAP service jurisdictions
- as of 1988, there were 24 grantees across the state

e) People served:

- Fiscal year 1987-88: community education: 38,219
  counseling: 25,385
- Fiscal year 1988-89: community education: 94,576
  counseling: 43,443
- Fiscal year 1989-90 (estimated): community education: 100,000
  counseling: 45,000

f) Other organizations: joint presentations with other entities are allowed if not co-sponsored and it is clear to audience that HICAP is speaking independently. There is a strict and specific written directive about this policy.

7) FUTURE ACTIVITIES

As required by the legislation, HICAP produces a comprehensive annual report. The report explains each of the project's activities, the impact and effectiveness of the program, statistics, case studies, and what future activities are planned. This report is an excellent source of information and would be very useful to states interested in starting a counseling program.

8) CONTACT PERSONS:

a) Mr. Wayne R. Lindley
State Program Manager
Health Insurance Counseling and Advocacy Program
California Department of Aging
1600 K Street
Sacramento, California 95814
(916) 323-7315

b) Ms. Bonnie Burns
21 Locke Way
Scotts Valley, California 95066
(408) 438-6677

IDAHO

1) PROGRAM

Senior Health Insurance Benefits Advisors (SHIBA)
Program started in 1986.

2) SPONSORSHIP

a) Idaho Department of Insurance (DOI)

b) Local sponsoring agencies: organizations which provide staff time on a pro bono basis to administer and coordinate local SHIBA programs.

3) FUNDING

a) Source:

1. Funded through the state department of insurance budget.

b) Amount and Distribution:

1. $119,000 for fiscal year 1989.

2. State DOI provides salaries for three staff positions, expenses and supplies.

4) ADMINISTRATION

a) State:

1. DOI provides statewide coordinator, or program specialist:

   - coordinates program with local organizations
   - administers program on statewide basis
   - collects and compiles data on program and prepares a monthly report on status of program
   - updates and distributes information on insurance policies: benefits and coverage
   - conducts trainings
   - ongoing contacts with other senior organizations in the state to distribute/exchange information
   - develops training materials, brochures and fact sheets to be used for training
   - statewide publicity efforts; public relations

2. Regional Coordinators (RC): two regional coordinators; one is responsible for the eastern part of state and the other oversees the northern part of Idaho:

   - conducts trainings
   - distributes information about insurance benefits to local coordinators
   - serves as a link between local coordinators and state coordinator
   - gives technical assistance to local coordinators
   - public speaking; group seminars

b) Local:

1. Local Coordinators (LC): there are seven local coordinators provided by Retired Senior Volunteer Program (RSVP) groups administering 40-45 sites:

   - manages program on a daily basis
   - organizes counseling and training sessions
   - reports to RC on status of program
   - collects data from volunteers on counseling sessions
   - provides local publicity and recruits volunteers

2. Volunteers:

   - attend initial and follow-up training
   - prepare counseling report forms
   - make appropriate referrals
   - keep client information confidential

5) TRAINING OF VOLUNTEERS

a) Initial training:

- six 4 hour sessions
- each session covers specific topic

b) Who trains:

- state and regional coordinators
- representatives from some public agencies will, on occasion, discuss specific topics at the trainings

c) Follow-up training:

- every two months, one 4 hour session
- informally as the need arises

d) Type of counseling:

- one-on-one counseling
- three staff people also conduct group seminars

e) Materials provided:

- training manual
- fact sheets and brochures on each topic
- consumer guides

f) Number of volunteers:

- 275 volunteers as of January 1990

6) SCOPE

a) Coverage:

- Medicare, Medigap, Medicaid, LTC, and home health care policies
- counseling on benefits covered by policy; assistance with filling out forms
- referrals for legal assistance made to legal aid organizations or to investigative division of DOI if issue involves insurance company/agent impropriety
- counselors will assist clients with filling out forms for Veteran's, social security or other public benefits

b) Public relations:

- no toll free number
- local and state publicity: press release, brochures
- announcements in senior organizations' and other groups' newsletters

c) Advocacy: not a part of the program but seniors are free to participate in advocacy on their own.

d) Geographic area covered:

- 40-45 sites serve 50% of the state

e) People served:

- 1989: approximately 3,000 clients counseled
- 1988: 1,900 clients counseled
- 1987: 1,100 clients counseled

f) Other organizations: representatives from public agencies sometimes do participate in trainings. No non-profit or for-profit groups are involved with program.

7) FUTURE ACTIVITIES

SHIBA hopes to hire more support staff and regional coordinators to reach more seniors and to provide a more developed structure to the program. SHIBA would also like to participate in more networking activities with other organizations for seniors in the state to ensure seniors access to information. SHIBA has become a source of information for many in the state and the program would like to see more services made available to seniors who are in need of assistance.

8) CONTACT PERSON

Mr. Ken Hurt
Program Specialist
Senior Health Insurance Benefits Advisors
Idaho Department of Insurance
500 S. 10th Street
Boise, Idaho 83720
(208) 334-2250

ILLINOIS

1) PROGRAM

Senior Health Insurance Program (SHIP)
Program started in the fall of 1988.

2) SPONSORSHIP

a) Illinois Department of Insurance (DOI)

b) Local sponsoring agencies: provide staff time on a pro bono basis to administer program on local level.

3) FUNDING

a) Source:

1. SHIP is funded through DOI budget

2. Funds come from the Producer Fund portion of the DOI budget.

b) Amount and Distribution:

1. Specific amount not provided.
2. Budget includes salaries for three staff people, expenses, supplies, and automobile.

4) ADMINISTRATION

a) State:

1. DOI provides Program Director who administers program on statewide basis:

   - implements policy for development of program, directs personnel, fiscal management
   - performs liaison and advisory work with executive and legislative branches of state government representing Insurance Commissioner on legislative matters affecting program
   - contacts agencies to set up local units
   - organizes and coordinates program statewide
   - reports to the Insurance Commissioner on the status of the program
   - public relations

2. Assistant program director:

   - conducts trainings
   - coordinates development of materials for program
   - provides technical assistance
   - updates insurance information
   - coordinates with local units on training and group education events

3. Trainer:

   - conducts trainings
   - disseminates information to local units
   - answers questions of unit coordinators and volunteers
   - coordinates with units to organize trainings and group education sessions
   - collects data from local units

b) Local:

1. Unit Coordinator (UC): local senior organizations provide staff to organize and administer program on local level. Extent of time spent on administering program depends upon needs of locality and senior population. Generally, UC will be responsible for:

   - coordinating and organizing the trainings
   - recruiting volunteers
   - reporting to Assistant Program Director
   - local publicity
   - assisting volunteers
   - collecting data from volunteers
   - distributing information to volunteers

UCs cannot be paid by SHIP and cannot be involved in insurance industry. The local sponsoring organizations are involved in senior citizens' activities, counseling.

2. Volunteers:

   - attend trainings
   - complete report form on each counseling session
   - volunteers may speak to groups in addition to providing one-on-one counseling
   - cannot be active in selling insurance
   - must keep client information confidential

5) TRAINING OF VOLUNTEERS

a) Initial training:

- three days, 6 hours each day

b) Who trains:
- Assistant program director (SHIP)
- Trainer (SHIP)

c) Follow-up training:

- every other month for approximately one and one-half hours
- conducted by SHIP staff
- as needed, updated with information on informal basis

d) Type of counseling:

- one-on-one counseling
- many volunteers prefer the team counseling approach
- mail/phone in questions
- public speaking and group education conducted by staff and volunteers

e) Materials provided:

- training manual
- brochures
- flyers, fact sheets
- consumer guides

f) Number of Volunteers:

- approximately 400 as of January 1990

6) SCOPE

a) Coverage:

- Medicare, Medigap, Medicaid, LTC, insurance options for teachers and federal employees upon retirement
- counseling on policy coverage; assistance with claims and appeals for Medicare; assistance with filling out forms
- referrals to appropriate legal aid organizations where client has potential legal problem
- insurance complaint file set up where violation may exist; complaint referred to person at Insurance Department and followed up by the volunteer to track action taken on complaint

b) Public relations:

- toll free number: 800-548-9034 (in state only)
- consumers guide
- brochures
- publicity in various newsletters and magazines
- state provides initial press release and publicity on availability of program in area

c) Advocacy: not a part of program but volunteers are informed that they may partake in advocacy on their own.

d) Geographic area covered:

- program is available in over 50% of the state

e) People served:

- over 1000 people served and over 2000 volunteer hours logged in 1989

f) Other organizations: Health Care Financing Administration (HCFA), regional office, is sometimes consulted about specific issues but no other organizations are involved in SHIP. SHIP wants to ensure that program is perceived as one in which objective information is provided.

7) FUTURE ACTIVITIES

SHIP would like to hire support staff to assist with administrative matters due to the staff's overwhelming workload. SHIP plans to return to the areas in which units are located to do more recruiting and to reestablish community contacts. SHIP reports great success with program which is evidenced by the fact that Assistant Program Director and Trainer are booked through September for training and public speaking events.

8) CONTACT PERSON

Ms. Bernadette Nolan, Program Director
Senior Health Insurance Program (SHIP)
Illinois Department of Insurance
320 West Washington St.
Springfield, Illinois 62767
(217) 782-0004

IOWA

1) PROGRAM

Protection and Advocacy through Community Training (PACT) Program started in January of 1990.

2) SPONSORSHIP

a) Insurance Division, Iowa Department of Commerce

b) Local sponsoring agencies: provide staff time and expenses on a pro bono basis for local units of program.

3) FUNDING

a) Source:

1. Legislature appropriated money to hire a Senior Health Insurance Advocate to develop PACT and train volunteers.

b) Amount and Distribution:

1. Money for salary for Advocate, expenses, and materials was provided by the appropriation.

4) ADMINISTRATION

a) State:

1. Insurance Division; Senior Health Insurance Advocate:

- conducts initial and follow-up trainings
- provides handbook and materials for volunteers
- public relations
- serves as information resource for the volunteers
- assists with volunteer recruitment
- publishes bimonthly newsletter for counselors
- collects data from the sponsoring units

b) Local:

1. Sponsoring units: local organizations, Area Agencies on Aging (AAAs), Retired Senior Volunteer Programs (RSVPs), and hospitals, provide staff time and resources on a pro bono basis to administer program on local level:

- organize training and counseling sessions
- assist in recruitment of volunteers
- collect counseling reports and forward them to insurance division
- inform volunteers of meetings and updates

2. Volunteers:

- attend initial and follow-up trainings
- provide one-on-one counseling at site or in home if senior requires such assistance; group education if desired
- keep all client information confidential
- complete a counseling report for each counseling session
- volunteers cannot be active in selling insurance

5) TRAINING OF VOLUNTEERS

a) Initial training:

- 15 hours over three days

b) Who trains:

- Senior Health Insurance Advocate
- other staff from Insurance Division

c) Follow-up training:

- bimonthly updates and information provided as it becomes available

d) Type of counseling:

- one-on-one counseling
- group education by Advocate and other staff
- volunteers may conduct group education seminars

e) Materials provided:

- handbook or training manual
- counseling materials; informational handouts
- bimonthly newsletter

f) Number of volunteers:

N/A

6) SCOPE

a) Coverage:

- Medicare, Medigap, Medicaid, LTC
- Medicare claims and appeals; other insurance claims
- education oriented: no recommendations are to be given by volunteers to clients due to possible liability problems
- assistance with filling out forms
- legal problems are referred to legal aid organizations

b) Public relations:

- no toll free number at this time
- statewide promotion provided by the Insurance Division
- local publicity by sponsoring unit

c) Advocacy is a part of the program. Volunteers will identify problems and the Insurance Division will develop legislation to address needs.

d) Geographic area covered:

- PACT hopes to have counseling programs in all counties of the state and in communities with populations of 500 or more

e) People served:

N/A

f) Other organizations: Department of Elder Affairs endorsed the program and was a force behind the implementation of the program. The Department will provide assistance in promoting PACT.

7) FUTURE ACTIVITIES

PACT is being implemented this year so the immediate goals involve expansion of program to reach as many seniors as possible. There is potential to expand the scope of coverage to include other regulatory areas of the insurance division including funeral plans, securities fraud, continuing care retirement communities and other types of insurance.

8) CONTACT PERSON

Ms. Kris Gross
Senior Health Insurance Advocate
Protection and Advocacy through Community Training
Iowa Insurance Division
Lucas State Office Building
Sixth Floor
Des Moines, Iowa 50319
(515) 242-5190

MARYLAND

1) PROGRAM

Senior Health Insurance Counseling Program (SHICP)
Program started in 1987 (end of calendar year).

2) SPONSORSHIP

a) Maryland Office on Aging (MD OoA)

b) Local contracting agencies: grants given to local organizations to organize and administer SHICP on local level.

3) FUNDING

a) Source:

1. State general funds given to the state Office on Aging and distributed via grant giving.

2. Some counties provide local matches: 20% match is required if program is a certain size and match can be in-kind services.

b) Amount and Distribution:

1. Fiscal year 1990: $169,406. Most of this money went to local Area Agencies on Aging (AAAs) to administer program. In addition, the funding provides for one part-time administrator on state level.

2. Budget for program has expanded every year; number of counties participating has increased.

3. The $169,406 figure for 1990 is matched with local funds by $72,292.

4) ADMINISTRATION

a) State:

1. Md OoA provides one part-time statewide administrative coordinator:

- administers and organizes program on state level
- distributes grants and coordinates program with local grantees; distributes information
- collects data from the various county programs
- prepares and submits monthly, quarterly and annual reports
- conducts some of the training
- publicity, guides, training manual

b) Local:

1. Grants are given through an application process. Most grants are given to AAAs in the various counties.

2. Local Coordinator (LC): staff person of grantee:

- attends meetings
- coordinates training for the county
- coordinates legal advocacy component with the local legal assistance provider which AAA is required to provide
- compiles data, prepares reports
- recruits volunteers
- fiscal reporting

3. Volunteers:

   - attend initial and follow-up trainings
   - keep records of activities
   - fill out forms on each session or other activity
   - keep client information confidential

5) TRAINING OF VOLUNTEERS

a) Initial training:

   - 2-3 days of training

b) Who trains:

   - state coordinator conducts the initial training
   - representatives from Medicare, Medical Assistance, social security, legal aid, Attorney General's Office and Delmarva Peer Review Organization will conduct training on specific topics.

c) Follow-up training:

   - there is an ongoing education process but it is left up to the LC to determine the kind of training which is needed

d) Type of Counseling:

   - usually one-on-one but seniors can call or write in

e) Materials provided:

   - training manual
   - consumer guides
   - referral list
   - fact sheets

f) Number of Volunteers:

   - 1989: 60 volunteers in the state

6) SCOPE

a) Coverage:

   - Medicare, Medigap, Medicaid, LTC and social security
   - Program provides claims assistance, counseling, public education and legal assistance

b) Reporting requirements:

   - local county organizations are required to provide monthly reports
   - quarterly demographic reports
   - an area plan to be completed in conjunction with sponsoring AAA in accordance with requirements of OoA
   - fiscal reporting

c) Public Relations:

   - toll free number: 1-800-AGE-DIAL (state office)
   - consumers guides
   - brochures and pamphlets
   - senior organizations' newsletters

d) Advocacy: not a part of program. AAAs are restricted in activities with regard to legislative advocacy.

e) Geographic area covered:

   - 14 out of 24 counties have the program

f) People served:

   - 1988: 2,314 clients; 2,636 counseling sessions; 5,640 were reached through public education

g) Outside organizations: there are no specific restrictions on the use of representatives from for-profit concerns but program generally does not use them.

7) FUTURE ACTIVITIES

In fiscal year 1991, the program will not expand. There will be the same amount of funding as in fiscal 1990.

8) CONTACT PERSON

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Coordinator
Senior Health Insurance Counseling Program
Maryland Office on Aging
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Room 1004
Baltimore, Maryland 21201
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MASSACHUSETTS

1) PROGRAM

Serving Health Information Needs of Elders (SHINE)
Program started in 1984.

2) SPONSORSHIP

a) Executive Office of Elder Affairs, State Unit on Aging

b) Local contracting agencies: grants given to local organizations to implement program in area.

3) FUNDING

a) Source:

1. Program included within the Division of Community Service Programs portion of the Executive Office's budget.

b) Amount and Distribution:

1. Budget funds 4 staff persons in State Unit on Aging office.

2. Grants are distributed to the various programs throughout the state.

4) ADMINISTRATION

a) State:

1. Executive Office funds Program Director, Trainer, Administrator, and Supervisor.

a. Program Director's responsibilities include:

- administers program on statewide basis and coordinates activities with Regional and Local Coordinators
- distributes grant monies
- develops training materials
- public relations; promotional activities
- prepares reports

b. Trainer's responsibilities include:

- conducts initial and follow-up trainings
- coordinates trainings with regional and local coordinators

c. Administrator's duties include:

- administers program on statewide level
- administrative matters: coordinating state, local, and regional groups

d. Supervisor's duties include:

- supervising the state office
- coordinating staff

b) Regional:

1. Regional Consortiums: senior organizations throughout the state which organize and implement program on regional level.

2. Regional Coordinators (RC): provided by Area Councils on Aging to coordinate through the consortiums on a regional level. There are 12 regional consortiums, 7 of which have regional coordinators. One RC is funded through Home Health Care Corporation. Duties of RC include:

   - coordinating the program on a regional level
   - serving as a liaison between the local and state programs
   - collecting and compiling data from the local programs
   - assisting with the organization and training activities of the local sites

c) Local:

1. Grants given to organizations for the purpose of organizing and administering SHINE program in area. Most of the organizations are Councils on Aging.

2. Local Coordinators (LC): staff person of grantee organization organizes program and is responsible for daily management of SHINE program in area. Duties include:

   - organize and coordinate training and counseling sessions
   - meet with state staff every two months to discuss status of program, updated information, problems that may arise
   - prepare monthly reports on program
   - fiscal reports for grant funds
   - conduct follow-up trainings

3. Volunteers:

   - attend initial and follow-up trainings
   - provide a one year commitment to the program
   - keep client information confidential
   - provide one-on-one counseling at site or in client's home
   - complete report forms on each counseling session

5) TRAINING OF VOLUNTEERS

a) Initial training:

- 6 sessions, 25-30 hours
- at 5th session, volunteers are given a take home exam to be completed and returned at the last session

b) Who trains:

- Program Director and Trainer
- representatives from various agencies are called upon to cover particular topics
- a representative from Blue Cross/Blue Shield trains on filling out Medex claims because BC/BS has the Massachusetts market for Medex

c) Follow-up training:

- conducted by LCs as the need arises
- Program Director meets with LCs once a month to go over issues and any problems that may arise

d) Type of counseling:

- one-on-one counseling
- volunteers may conduct group seminars
- staff conducts group seminars

e) Materials provided:

- training manual
- guide to assist volunteers through the insurance system
- brochures, fact sheets and consumer guide

f) Number of volunteers:

- 200 volunteers as of January 1990

6) SCOPE

a) Coverage:

- Medicare, Medigap, Medicaid eligibility, LTC, HMOs, state/federal employees insurance programs, state hospital benefits, continuing care, discharge laws, and retirees' benefits
- counseling on insurance coverage and the options; assistance with claims and appeals, including DRG claims; reimbursement problems; assistance with filling out forms
- volunteers will refer client to Massachusetts Peer Review Organization, MMAP-Massachusetts Medicare Assistance Project, the LTC Ombudsman, or any other appropriate agency

b) Public relations:

- no toll free number but Executive Office can be called
- brochures, flyers, announcements in newsletters
- local, regional, state programs all provide publicity

c) Advocacy is a part of the program. Program Director will present issues to the legislature when they are brought to her attention through the program.

d) Geographic area covered:

- 70 sites within the 12 regional consortiums reach one-third of the state.

e) People served:

- 3,000 per year is the estimate

f) Other organizations: some agencies are called upon to cover specific topics. Staff person is always in attendance when representative from another group is training. There are no prohibitions against the use of representatives from for-profit concerns - the decision is discretionary.

7) FUTURE ACTIVITIES

SHINE covers only one-third of the state and the program would like to expand to reach more seniors. Due to current budget restraints, however, the program does not envision much expansion over the next year. There are requests from a number of areas for regional consortiums.

8) CONTACT PERSON

Ms. Maureen Barton, Program Director
Serving Health Information Needs of Elders
Executive Office of Elder Affairs
38 Chauncey Street
Boston, Mass. 02111
(617) 727-7750

NEW JERSEY

1) PROGRAM

Senior Health Insurance Program (SHIP)
Program started in 1987.

2) SPONSORSHIP

a) Sponsorship:

New Jersey Department of Community Affairs (DCA)
Division on Aging

b) Cooperating Agencies:

1. New Jersey Department of Insurance (DOI) Division of Public Affairs: provides training staff.

2. Health Care Financing Administration (HCFA), Region II office, Medicare: assists with trainings and provides information on Medicare benefits.

c) Local contracting agencies: Area Agencies on Aging (AAAs) located in each county are given funds to organize and administer SHIP on local level.

3) FUNDING

a) Source:

1. Funded in 1986 through a special appropriation in Governor's budget.

2. Funding expires on June 30, 1990.

3. Bill to fund SHIP on permanent basis is pending in the state legislature.

b) Amount and distribution:

1. $100,000 for fiscal 1989.

2. DCA receives grant and then distributes various amounts to county AAAs based on percentage of population over 65 in the particular area.

4) ADMINISTRATION

a) State:

1. DCA provides statewide administrative coordinator:
   - coordinates program with local contracting agencies
   - collects data from local organizations; prepares reports
   - disseminates information to local groups
   - distributes funds
   - statewide public relations

2. DOI provides training director and assistant training director:

   - develop training materials and conduct trainings throughout the state
   - provide technical assistance to the local organizations

b) Local:

1. Local Coordinator (LC): each county has a local coordinator who is an employee of the contracting agency. In two-thirds of the counties, the AAA administers program; in the remaining counties, the AAA contracts with Retired Senior Volunteer Program (RSVP) or other social service agencies to administer program. The LC is responsible for:

   - managing the program on a daily basis
   - recruiting volunteers, arranging sites for the trainings and locations for counseling
   - arranges for clients to meet with volunteers
   - collects reports of counseling activities and compiles information into monthly report to be sent to SHIP coordinator at DCA
   - public relations in the community

2. Volunteers:

   - attend initial and follow-up training
   - make a commitment to counsel for six months
   - SHIP report form must be completed and sent to LC for each counseling session
   - client information must be kept confidential

5) TRAINING OF VOLUNTEERS

a) Initial training:

- 24 hours of training over 4 day period
- 12 hours on Medicare; 12 hours on Medigap insurance programs

b) Who trains:

1. Medicare: regional HCFA office makes representatives available for initial and follow-up training.

2. Medigap insurance programs: director and assistant director of training from DOI.

3. Others: sometimes others are asked to train on specific issues, i.e. representatives from Blue Cross/Blue Shield.

c) Follow-up training:

- quarterly
- conducted by SHIP training people and others from HCFA or other public agencies

d) Type of counseling:

- one-on-one or in pairs if client is homebound
- waiver of liability forms for clients to sign to protect in event erroneous advice is given out

e) Materials provided:

- comprehensive training manual
- statewide information and referral directory

f) Number of volunteers:

- 250 volunteers as of January 1990
- program has trained 500 volunteers

6) SCOPE

a) Coverage:

- Medicare, Medigap, LTC, HMOs, and indemnity insurance
- counseling; assistance with completing Medicare and other insurance claims; assisting with filling out forms; assisting with appeals

b) Public relations:

- toll free number for information: 800-792-8820
- consumers guide
- brochures, publicity

c) Advocacy: is part of program. Advocacy includes assisting clients with appeals and meeting with Medicare provider to discuss systemic issues.

d) Geographic area covered:

- all 21 counties served by 130 sites

e) People served:

- 1989: approximately 10,000 clients counseled
- 1988: 7,000 served
- 1987: 2,000 served

f) Other organizations: public agencies will assist with training upon request.

7) CONTACT PERSONS

a) Ms. Debbie Breslin
Director of Training/SHIP
New Jersey Dep't of Insurance: Division of Public Affairs
CN 325
Trenton, New Jersey 08625-0807
(609) 984-6953

b) **Ms. Theresa Dietrich**
SHIP Coordinator
New Jersey Dep't of Community Affairs: Division on Aging
CN 807
Trenton, New Jersey 08625-0807
(609) 292-4303

NEW MEXICO

1) PROGRAM

Health Insurance and Benefits Assistance Corps (HIBAC) Program started in 1988.

2) SPONSORSHIP

a) **New Mexico State Agency on Aging (AOA) The state legislature appropriates funds to State AoA to implement a Medicare and Medigap Counseling Program (MMCP).**

b) **Local sponsoring organization: non-profit senior centers provide local support on a pro bono basis.**

3) FUNDING

a) Source:

1. Part of state AOA base budget.

2. Started in 1988 as a demonstration project and was incorporated into AOA budget in 1989.

b) Amount and Distribution:

1. $45,000 for fiscal year 1990 directly to AOA.

2. Funds go directly to AOA for salaries, training expenses and supplies.

4) ADMINISTRATION

a) State:

1. AOA provides one full time staff person, HIBAC Coordinator:

   - coordinates and administers program on state level
   - provides ongoing support and technical assistance for local HIBACs
   - provides statewide publicity
   - assists in the training of volunteers

2. Trainer: HIBAC contracts with Office of Senior Affairs for a part-time trainer who travels with coordinator to conduct trainings throughout the state.

3. There is a professional intern who is working from 11/89-4/90 to develop a HIBAC in a rural, predominantly Hispanic Community. Intern is provided by Asociacion Pro Personas Mayores.

b) Local:

1. Steering Committee: 3-5 members of the community direct program locally and work with the local coordinator (LC).

2. Local Coordinator (LC): Local, recognized volunteer in the community is recruited to be the LC. Staff persons of local senior organizations may take on duties of an LC. Most LCs are sponsored by senior citizen centers. Responsibilities of the LC are:

- work with Steering Committee
- recruit and screen volunteers
- schedule space for training, counseling
- provide consultation and assistance to the HIBAC volunteers at least once a month
- local publicity
- complete monthly statistical reports on the volunteers' time and sessions

3. Volunteers:

- attend initial and follow-up training
- sign volunteer work commitment contract: 8 hours per month for at least 6 months
- provide one-on-one counseling
- keep client information confidential

5) TRAINING OF VOLUNTEERS

a) Initial training:

- 3 full day sessions

b) Who trains:

- part-time trainer from Office of Senior Affairs and the state coordinator

c) Follow-up training:

- one half-day every six months

d) Type of Counseling:

- one-on-one counseling
- coordinator and trainer also conduct group seminars

e) Materials provided:

- training manual
- brochures, pamphlets and fact sheets

f) Number of Volunteers:

- 170 trained volunteers currently in program

6) SCOPE

a) Coverage:

- Medicare, Medigap, state assistance programs, SSI, LTC policies, and legal issues
- information and referral; assistance with filling out forms and filing claims and appeals; information and referral on state and federal assistance programs
- legal problems referred to Lawyer Referral for the Elderly

b) Public relations:

- toll free number 800-432-2080 (Office on Aging number: in state only)
- brochures, pamphlets
- local and statewide publicity.

c) Advocacy: not a part of program

d) Geographic area covered:

- 25 counseling sites in 13 out of 33 counties in the state

e) People served:

-1989: 1,000 persons counseled

f) Other organizations: program is cosponsored by a local organization, typically the senior center in the area. In addition, AARP provides two sites

7) FUTURE ACTIVITIES

HIBAC coordinator hopes to expand the program to provide counseling to more seniors. In addition, if funding was available, HIBAC would create another level of organization, regional, and would fund the local coordinators directly. However, due to the budget reductions, there will be limited expansion of the program. The state coordinator will develop an assessment instrument to evaluate the current volunteers. Travel will be limited to brief refresher trainings of current volunteers and administration of the assessment instrument.

8) CONTACT PERSON

Ms. Denese Mueller
State HIBAC Coordinator
New Mexico Agency on Aging
224 East Palace Ave., 4th Floor
Santa Fe, New Mexico 87501
(505) 827-7640

NORTH CAROLINA

1) PROGRAM

Seniors Health Insurance Information Program (SHIIP)
Program started in 1986.

2) SPONSORSHIP

a) North Carolina Department of Insurance (DOI)

- Assistant Commissioner, Supervisor of Program and three trainers provided by DOI

3) FUNDING

a) Source:

1. Program funds are included in the continuation budget of DOI.

b) Amount and distribution:

1. $181,000 for fiscal year 1989
2. Budget used for salaries of supervisor, three trainers and secretary; expenses and supplies.

4) ADMINISTRATION

a) State:

1. DOI provides an Assistant Commissioner and Supervisor who administer program:
    - report to the Commissioner on the status of program
    - coordinate and administer on state level
    - contact local organizations to obtain sponsors for program
    - prepare training manuals
    - network with other aging agencies in the state
    - state publicity and promotion
    - prepare reports on the program
    - technical assistance to the local programs
2. Three Trainers:
    - conduct trainings throughout the state
    - group education and public speaking
    - exchange information with and update the local coordinators

b) Local:

1. Local Coordinator (LC): local organizations provide staff time to administer and coordinate program. The amount of time and involvement staff persons devote to duties of LC depends upon needs of particular area. Responsibilities of LC include:

- recruiting volunteers
- local publicity
- organizing the training and counseling for area
- collects data for state coordinator
- maintains contact with trainer to update information and discuss program

2. Volunteers:

- attend initial and follow-up training
- complete counseling report form for each session
- no commitment required but low dropout rate
- coordinate activities with LC
- keep client information confidential

5) TRAINING OF VOLUNTEERS

a) Initial training:

- 6 sessions, 3 hours each
- 50% of those who take initial training stay on

b) Who trains:

- three staff trainers

c) Follow-up training:

- once every two months
- conducted by SHIIP trainers

d) Type of counseling:

- individual for the most part but group counseling can be done: it is up to LC and needs of county
- senior citizens can phone or mail in questions to state or local contact but client will be directed to local program for assistance

e) Materials provided:

- comprehensive training manual which is frequently updated
- fact sheets
- consumer guides; insurance comparison guide

f) Number of Volunteers:

- 1500 volunteers as of January 1990

6) SCOPE

a) Coverage:

- Medicare, Medigap and LTC
- Information and referral based program: counseling on insurance coverage and options
- depending on the type of problem, client may be referred to Department of Human Services (Medicaid); legal services organizations; or Equicor (private company which contracts with the federal government to handle state of North Carolina Medicare Part B claims)

b) Public relations:

- flyers and brochures on program
- consumers guide
- publicity through senior organizations, i.e. announcements in newsletters
- toll free number 800-443-9354 (in state only)

c) Advocacy is not a part of program.

d) Geographic area covered:

- 84 out of 100 counties in state are served by program

e) Persons served:

- 1989: 3,000 persons counseled

f) Other organizations: there are no specific restrictions but non-profits and for profits are not involved in training. May be viewed as conflict of interest to have any private concerns involved.

7) FUTURE ACTIVITIES

Program plans to continue to train volunteers in the counties which do not yet have trained volunteers and to set as a priority the promotion of the program to consumers statewide. The program plans to expand into more counties.

8) CONTACT PERSONS

a) Ms. Alice Garland
Assistant Commissioner
Department of Insurance
P.O. Box 26387
Raleigh, North Carolina 27611
(919) 733-0433

b) Ms. Carla Suitt
Supervisor/SHIIP
N.C. Dep't of Insurance
P.O. Box 26387
Raleigh, N.C. 27611
(919) 733-0111

OHIO

1) PROGRAM

Pilot program for 1990: Pilot Health Insurance Information Program for Summit County Older Adults
Expected date of start-up: May 1990.

2) SPONSORSHIP

a) Consortium:

1. State of Ohio Attorney General: one assistant attorney general will be provided to assist with the implementation of the program.

2. Senior Workers Action Program, Inc. (SWAP): a community based organization which will be responsible for administering program on the local level.

3. Local Service Site Organizations: six organizations in the county will provide sites and assist with the administration of the program.

3) FUNDING

a) Source and Distribution:

1. There is no specific appropriation set aside for the program.

2. The activities contributed by each organization are funded by their own budget, i.e. the assistant attorney general provided by the Attorney General's office.

4) ADMINISTRATION

a) State:

1. State Attorney General's Office: responsible for coordinating initial stages of program:

- select a State Program Director
- recruit and assist with the training of volunteers
- assist in development of program and publicity
- provide technical assistance
- develop reporting system and maintain data

b) Local:

1. Local Advisory Council: members of the program participants and other representatives from the community. The Council will assist with the planning and developing of operational procedures for the local program.

2. Local Coordinator: SWAP will coordinate local activities:

   - assist in the development of the program
   - daily management of program
   - assist with publicity on local level
   - assist with training curriculum and arrangements for training sessions
   - recruit, enroll, provide orientation and place trained volunteers at the Local Service Sites
   - assist in developing a reporting system
   - provide monthly reports to the State Program Director

3. Local Service Site Organization to be set up within Summit County. There are six sites which include four hospitals and senior centers. Sites will:

   - designate person to serve as liaison for program
   - receive incoming calls from seniors
   - schedule individual informational sessions
   - provide space for the volunteer
   - assist in the organization of training sessions
   - provide local publicity

4. Volunteers:

   - attend initial and follow-up training sessions
   - complete report form for each session
   - keep client information confidential
   - make a one year commitment to the program

5) TRAINING OF VOLUNTEERS

a) Initial Training:

- 18 hours over approximately 6 days

b) Who trains:

- representatives from within the insurance industry
- benefits counselors from various corporations
- representative from the Department of Human Services to train in the area of Medicaid

c) Follow-up training:

- there will be follow-up training but details have not yet been worked out

d) Type of counseling:

- individual but it is up to the Local Advisory Council to determine needs of county
- group education

e) Materials provided:

- fact sheets
- training manual
- updates

6) SCOPE

a) Coverage:

- Medicare, Medigap, LTC, Medicaid, right to continue or convert employer sponsored group health insurance upon retirement, and COBRA rights
- information and referral only
- for assistance with filling out forms or making claims, counselor will refer client to particular agency or organization for assistance, i.e., AARP's MAP program for Medicare questions; Department of Human Services for Medicaid; legal aid organizations for legal problems

b) Advocacy: will not be a part of program

c) Public Relations:

- state and local joint effort on publicity
- posters, flyers
- articles in senior citizen paper (statewide)
- the local service site organizations will send out information and place articles or announcements in local papers

d) Geographic area covered:

- pilot program will serve one county and may expand depending upon resources

e) Other organizations: representatives from the insurance industry and other corporations participate in the training efforts

7) FUTURE ACTIVITIES

Toward the end of the year, an assessment of the program will be made. At that time, the program will make a decision about expansion. The intent at this time is to expand the program into other counties on an incremental basis.

8) CONTACT PERSON

Mr. Joseph Mancini
Office of the Attorney General
Health, Education and Human Services Section
State Office Tower
30 East Broad Street
Columbus, Ohio 43215
(614) 466-8600

WASHINGTON

1) PROGRAM

Senior Health Insurance Benefits Advisors (SHIBA)
Program began in 1979.

2) SPONSORSHIP

a) Office of the Washington State Insurance Commissioner

b) Sponsoring agencies: non-profit senior organizations provide local support.

3) FUNDING

a) Source:

1. SHIBA is included in the Insurance Commissioner's budget.

b) Amount and Distribution:

1. Four full time staff persons are provided by Commissioner's office

2. Some grants are given to the local groups.

3. Budget amount not provided.

4) ADMINISTRATION

a) State:

1. Deputy Commissioner:

- administers program on state level
- coordinates with local sponsoring agencies
- collects data from local programs

2. Regional Representatives: the state is divided into 3 regions and one representative is assigned to conduct trainings in each of the three regions.

b) Local:

1. There are 30 local SHIBA groups throughout state sponsored by various agencies such as RSVP, retired teachers associations, and senior services centers.

   - the local group coordinates trainings, counseling sessions, and reports to the state
   - local group has control over the organization of program

2. Volunteers:

   - attend initial and follow-up trainings
   - report to the local group
   - keep client information confidential
   - conduct one-on-one training sessions or group education seminars if desired

5) TRAINING OF VOLUNTEERS

a) Initial training:

- 12 hours of training on Medicare, Medigap, and LTC insurance

b) Who trains:

- Deputy Commissioner and 3 regional representatives conduct trainings
- until recently, representatives from the health insurance industry provided assistance at the trainings but SHIBA now prohibits such involvement

c) Follow-up training:

- monthly discussions, informal training, as needed

d) Type of Counseling:

- one-on-one for the most part but group education and counseling are sometimes conducted by the trainers or volunteers

e) Materials provided:

- comprehensive training manual

f) Number of Volunteers:

- 350-400 volunteers as of January 1990

6) SCOPE

a) Coverage:

- Medicare, Medigap, LTC and other health insurance as the need arises
- program does not cover medicare claims and appeals; referrals made for assistance with claims and appeals
- published list of organizations to refer clients

b) Public Relations:

- state publishes materials, brochures, training manuals, monthly flyers, and updates
- publicity in newsletters of various organizations
- state and local publicity efforts
- toll free number: 800-562-6900 (Hotline number: Insurance Commissioner's office)

c) Advocacy is not a part of the program

d) Geographic area covered:

- 3 regions across the state have 25-30 sites
- 35 out of 39 counties served by the program

e) People served:

- no estimates at the current time but program hopes to have a grant to hire a person to compile statistics

f) Other organizations: there is now a prohibition on the involvement of other organizations in the training of volunteers.

7) FUTURE ACTIVITIES

SHIBA will be compiling statistics on the program. It will be interesting to see the impact this program has in light of the fact that it was the first volunteer counseling program for seniors to be established and has served as a model for other states.

8) CONTACT PERSON

Ms. June Mulcahy
Deputy Commissioner
Insurance Building
Olympia, Washington 98504
(206) 753-2408

WISCONSIN

1) PROGRAM

The Elderly Benefits Assistance program
Program was started in 1978 as a pilot project in 6 counties.
The program was implemented statewide by 1984.

2) SPONSORSHIP

a) Department of Health and Human Services, Bureau on Aging

b) Area Agencies on Aging: administrative responsibilities are divided among six AAAs which administer program in the particular region. The six AAAs cover the state's 72 counties.

3) FUNDING

a) Source:

1. Federal funds from the Older Americans Act, Title III-B, provide a substantial portion of the funds.

2. State monies are used in combination with the federal funds to pay for the administration of the program, the salaries of the benefits specialists and a portion of the legal assistance component of the program.

b) Amount and Distribution:

1. $1,520,000 per year: includes state and federal funds.

2. County and regional components are paid with these funds.

4) ADMINISTRATION

a) State:

1. Department of Health and Social Services, Bureau on Aging: coordinates program statewide. A Benefit Specialist Program Liaison and a Grant Coordinator are provided to coordinate administrative and grant giving functions statewide.
2. Grant program: grants are distributed to AAAs in state to provide for salaries and training of benefits specialists in AAA area. Program contracts with regional attorneys to conduct the trainings.

b) Regional:

1. Area Agencies on Aging: there are six AAAs which oversee 72 counties statewide. The AAA can use the grant to organize the program itself - hire benefits specialists and trainers - or contract out for services to operate the program.

c) Local:

1. Benefits Specialists: paid professional staff of the AAA or contract employees are the benefits specialists who cover particular counties. Depending upon the size and population of the county, there may be one part-time benefits specialist or six, as in Milwaukee. The responsibilities of the paid specialists are:

   - provide information to senior citizens about any benefits to which they may be entitled
   - provide group education or one-on-one counseling to seniors in the areas of health insurance, housing, and any other assistance/benefits available
   - provide reports on client sessions
   - provide paralegal assistance i.e. representing clients at administrative hearings
   - attend initial and follow-up training
   - remain informed about changes in the various programs affecting seniors

2. Legal assistance and training: the programs can contract for the services of attorneys to conduct the trainings or the AAA can provide for such assistance directly. The regional attorneys conduct trainings, provide support and technical assistance to benefits specialists and represent clients in legal matters.

3. Center for Public Representation, Legal Services of Northeastern Wisconsin, and Legal Action of Wisconsin are organizations which are under contract to provide legal assistance for clients referred by benefits specialists and also provide backup, training, and assistance with coordination of the program for five of the AAAs.

5) TRAINING OF BENEFITS SPECIALISTS

a) Initial training:

- three days

b) Who trains:

- regional attorneys

c) Follow-up training:

- monthly, one day of training
- yearly, statewide 2 day training

d) Type of counseling:

- one-on-one counseling
- group education and counseling

e) Materials provided:

- training manual
- updates on information
- ongoing informational process with regional attorneys

f) Number of specialists:

- approximately 80 paid professional specialists statewide

6) SCOPE

a) Coverage:

- Medicare, Medigap, Medicaid, any other insurance or public assistance program
- community education, individual counseling, legal assistance, filling out forms, filing claims and any other form of assistance requested

b) **Public relations:**

- **toll free number, 800-242-1060, is operated by the Board on Aging and Long Term Care. Staff of Hotline will often refer clients to Benefits Specialists program when matter is too complicated to handle over the phone.**
- **brochures and pamphlets**

c) Advocacy is part of the program but there is a restriction on lobbying activities under the Older Americans Act.

d) Geographic area covered:

- all 72 counties of the state are served by six AAAs

e) People served:

- 1988: 35,260 senior citizens were served
- 1989: 38,500 persons served

f) Other organizations: other than those organizations with which the AAAs contract, there are no outside organizations involved in the program.

7) FUTURE ACTIVITIES

The program will be modified to respond to the recommendations of the current federal grant project which is assessing the program with particular emphasis on targeting minorities.

8) CONTACT PERSONS

a) Ms. Jane A. Raymond
Benefit Specialist Program Liaison
Wisconsin Bureau on Aging
1 West Wilson Street
P.O. Box 7851
Madison, Wisconsin 53707-7851
(608) 266-2568

b) Ms. Nichelle Mitchem, Grant Coordinator
Elderly Legal Services
Wisconsin Bureau on Aging
1 West Wilson Street
P.O. Box 7851
Madison, Wisconsin 53707-7851
(608) 266-5456

APPENDIX II

LIST OF CONTACT PERSONS OF THE COUNSELING PROGRAMS

CALIFORNIA

Mr. Wayne R. Lindley
California Department of Aging
Program Manager
Health Insurance Counseling &
Advocacy Program (HICAP)
1600 K Street
Sacramento, California 95814
(916) 323-7315

ILLINOIS

Ms. Bernadette Nolan
Program Director
Senior Health Insurance Program
(SHIP)
Illinois Department of Insurance
320 West Washington Street
Springfield, Illinois 62767
(217) 782-0004

MARYLAND

Ms. Michelle Holzer
Coordinator of Senior Health
Insurance Counseling Program
Maryland Office on Aging
301 West Preston Street
Baltimore, MD 21201
(301) 225-1270

NEW MEXICO

Ms. Denese Mueller
Program Manager
Health Insurance Benefits
Assistance Program (HIBAC)
New Mexico Agency on Aging
224 East Palace Ave.
Fourth Floor
Santa Fe, New Mexico 87501
(505) 827-7640

NORTH CAROLINA

Ms. Alice Garland
Assistant Commissioner
Dep't of Insurance
Senior Health Insurance
Information Program (SHIIP)
P.O. Box 26387
Raleigh, North Carolina 27611
(919) 733-0433

WASHINGTON

Ms. June Mulcahy
Deputy Commissioner
Senior Health Insurance
Benefits Advisors (SHIBA)
Insurance Building
Olympia, Washington 98504
(206) 753-2408

IDAHO

Mr. Ken Hurt
Program Specialist
Senior Health Insurance
Benefits Advisors(SHIBA)
Idaho Department of Insurance
500 S. 10th Street
Boise, Idaho 83720
(208) 334-2250

IOWA

Ms. Kris Gross
Senior Health Insurance
Advocate
PACT: Protection & Advocacy
through Community Training
Iowa Insurance Division
Lucas State Office Bldg.
Sixth Floor
Des Moines, Iowa 50319
(515) 242-5190

MASSACHUSETTS

Ms. Maureen Barton
Program Director
Serving Health Information
Needs of Elders (SHINE)
Executive Office of
Elder Affairs
38 Chauncey Street
Boston, Mass. 02111
(617) 727-7750

NEW JERSEY

Ms. Theresa Dietrich
Coordinator: Senior Health
Insurance Program (SHIP)
Dep't of Community Affairs
Division on Aging
CN 807
Trenton, New Jersey 08625
(609) 292-4303

OHIO (Pilot Program)

Mr. Joseph Mancini
Office of Attorney General
Health, Education and Human
Services Section
State Office Tower
30 East Broad Street
Columbus, Ohio 43215
(614) 466-8600

WISCONSIN

Ms. Jane Raymond
Benefit Specialist Program
Liaison
Wisconsin Bureau on Aging
1 West Wilson Street
P.O. Box 7851
Madison, Wisconsin 53707
(608) 266-2568

Item 5

HIAA

RESEARCH BULLETIN

Older Americans and Their Health Coverage

Thomas Rice, Ph.D.
Katherine Desmond
University of North Carolina

Jon Gabel
Health Insurance Association of America

October 1989

Executive Summary

This Research Bulletin reports findings from a national telephone survey of 500 elderly Americans conducted in April and May 1989. The elderly responded to a host of questions including: (1) knowledge of the catastrophic legislation; (2) concerns about remaining gaps in Medicare coverage; (3) satisfaction with changes in Medicare brought about by the recent legislation; (4) private health coverage and satisfaction with it; and (5) plans for dropping private coverage.

Survey results indicate that despite the extensive publicity, the elderly still know very little about the basic aspects of the catastrophic legislation. The average percentage of correct answers for nine questions on recent changes was only 28 percent.

The elderly are very worried about incurring any out-of-pocket costs and strongly desire complete coverage with no coinsurance or deductibles. For example, 66 percent are "very concerned" about having to pay for the first $600 of prescription drug costs not covered by Medicare.

Medicare beneficiaries are substantially less satisfied with the cost and benefits of the Medicare program today than they were prior to the catastrophic legislation. More than 70 percent expressed satisfaction with the cost of the Medicare program before the legislation, but only 30 percent are satisfied after the legislation.

More than 78 percent of the older people in the sample had private insurance coverage to supplement their Medicare coverage. (Individuals with dual Medicaid-Medicare coverage were excluded from the sample.) Nearly 90 percent of owners report satisfaction with benefits, while 75 percent were satisfied with their cost of private coverage. Despite the recent catastrophic legislation, 83 percent of the elderly plan to renew their policies, 2 percent plan to drop them and the remaining 15 percent "don't know." The "informed" segment of the sample were equally likely to renew their policies as those who were not briefed about changes in Medicare benefits. Fear of any remaining costs not covered by Medicare is a major reason why the elderly plan to retain their private coverage. Hence, insurance companies that provide dependable coverage against these expenses will continue to attract the older population.

3

Older Americans and Their Health Coverage

In 1988, Congress made substantial changes in the Medicare program — the first major changes in the benefit and financing packages that beneficiaries have seen in the nearly 25 years since the program was enacted. Rather than rejoicing over improved benefits, however, there has been a great deal of public opposition to the Medicare Catastrophic Coverage Act among the elderly. Complaints center largely on its financing methods, but also on what some people consider to be its shortcomings in protecting older Americans from catastrophic health care expenses.

There are now a number of proposals before Congress to revamp the legislation. These include making the additional benefits and payments (monthly premiums and additional income taxes) voluntary, lowering the maximum income tax liabilities, spreading the cost of program benefits beyond the elderly and even repealing the new benefits. It is difficult for Congress to act, however, since it is unclear whether the public opposition is that of a vocal (and relatively wealthy) minority or, alternatively, is broad-based. (As this *Research Bulletin* goes to press, Congress is poised to enact changes in the Medicare Catastrophic Coverage Act with any resulting legislation holding broad implications for this study.)

Beyond the issue of the legislation's popularity, another issue of concern is what spillover effects, if any, will be felt in the private insurance market. More than 70 percent of Medicare beneficiaries own private health insurance to supplement Medicare,[1] an estimated $13 billion market in 1986.[2] A question raised by the legislation is whether beneficiaries will now drop their private health insurance coverage because they believe Medicare's new benefits will provide sufficient protection.

◆ The Medicare Catastrophic Coverage Act

The Medicare Catastrophic Coverage Act makes a number of changes in both program benefits and financing that will be phased in over the next several years. The three most important new benefits involve hospital care, Part B expenses (primarily physician care) and prescription drugs. Beginning in 1989, beneficiaries are no longer responsible for substantial daily copayments for hospital stays exceeding 60 days. Furthermore, they pay a $560 hospitalization deductible only once in a single calendar year. Starting in 1990, there will be a $1,370 annual cap placed on Part B copayments. Prescription drug coverage — an entirely new Medicare benefit — will be phased in between 1990 and 1993; ultimately, Medicare will pay 80 percent of drug costs after an annual deductible of approximately $600 is met.

There are other benefit enhancements as well, most notably liberalization of Medicaid regulations that allow the spouse of a nursing home resident to retain enough income to avoid impoverishment. Although there were some modest changes in the Medicare nursing home benefit, one of the primary complaints about the legislation is that it does not extend Medicare coverage to long-term nursing home care. This type of care is most likely to impoverish the elderly.[3]

Unlike prior Medicare benefits, the new ones are to be financed entirely by program beneficiaries. Most of the cost will be funded through the controversial supplemental premium, which is actually an additional amount of income tax to be paid by an estimated 40 percent of the elderly. The maximum tax liability, which will be paid by less than 10 percent of the elderly, is scheduled to be $800 per person ($1,600 for a couple). In addition to the supplemental premium, the Part B monthly premium charged to all program beneficiaries whose incomes are above the poverty level will increase by $4.

After the benefits are fully phased in, the following expenses will still be borne by beneficiaries (or by their private insurance policies): the initial $560 hospital deductible for Part A; the $75 Part B deductible and 20 percent coinsurance payment until annual expenses of $1,370 are incurred; all nonassigned physician charges above what Medicare deems to be reasonable; the first $600 of prescription drug costs; and 20 percent of all additional prescription drug costs during a year.

◆ Survey Methodology

Survey results are from a telephone survey of 500 Medicare beneficiaries which was conducted in April and May of 1989 to determine their level of understanding about and satisfaction with Medicare and private supplemental insurance. The survey, carried out by Response Analysis, Inc., of Princeton, New Jersey, was based on a nationally representative sample chosen using random-digit dialing.

Because only those households with at least one person age 65 or more and on Medicare were accepted into the sample, only a small fraction of households contracted were eligible. Individuals who were dually eligible for Medicare and Medicaid were not interviewed because they normally do not purchase private health insurance to supplement Medicare.

Response Analysis was able to screen eligibility information for 71 percent of the telephone numbers of residential households with working telephones. The majority of the remaining 29 percent hung up before or during the screening interview. Of the eligible households, 85 percent did not have anyone age 65 or older, and a few others were excluded because the elderly residents were not eligible for Medicare or were dually eligible for Medicare and Medicaid. Of the households that met all of our eligibility standards, 68 percent completed the interview. On average, there were six calls necessary per completed interview; the interviews themselves lasted an average of 19 minutes. To ensure the representativeness of the sample, when there was more than one person age 65 or older in the household, the person with the next birthday was chosen for the interview.

Of the 500 completed interviews, 391 (78 percent) owned private insurance to supplement Medicare and 109 did not. We employed a split-sample technique to assess the impact of respondents' level of understanding of the recent changes in Medicare. Interviewers briefed half of the private insurance owners on the details of the new legislation's benefits, but did not brief the other half. Instead, interviewers quizzed them to determine their level of understanding. Nonowners also took the quiz.

Interviewers asked elderly respondents whether they were or someone else was more familiar with their private health insurance policies. If someone else was said to be more familiar, the interviewers tried to contact that person to find out the desired information about health insurance coverage, including whether the original respondent was likely to drop his or her health insurance policy in the wake of the Medicare Catastrophic Coverage Act. Curiously, only 14 of the 391 policy owners said that someone else was more familiar with their insurance. In these 14 cases, we used the information from the original elderly respondent to construct all variables except those concerning their experience and satisfaction with private health insurance. We suspect that the reason that so few people claimed that someone else was primarily responsible for insurance decisions was that the question was asked well after the interview had begun, and respondents were reluctant to admit that they were not the best person to speak with or did not want to bother other household members.

Table 1 shows some of the characteristics of the sample, in comparison with national figures published in the *Statistical Abstract of the United States*.[4] Although the survey sample differs somewhat from the national

Table 1 The Sample Compared to the Elderly Population as a Whole

Demographic Characteristic	HIAA Sample	National Sample*
Age		
65-74	65.2%	59.3%
75 and over	34.8	40.7
Sex		
Male	33.6	40.6
Female	66.4	59.4
Race		
Black	5.8	8.4
Hispanic	0.4	3.0
Caucasian	93.8	88.6
Marital Status		
Married	47.9	55.7
Unmarried	52.1	44.3
Education		
0-11 Years	38.2	48.8
High School Graduate	32.1	30.8
Some College	29.7	20.3
Employment Status		
Employed	7.7	10.7
Not Employed	92.3	89.3

*Source: *Statistical Abstract of the United States*, 1989 (see note 4)

figures, no clear pattern emerges. Compared with the national figures, survey respondents were more likely to be (or claim to be) somewhat younger, female, white, unmarried, better educated and not employed. Some of the differences probably can be explained by the nature of the survey. For example, blacks may have been underrepresented because individuals who were eligible for both Medicare and Medicaid (the poorest of the elderly) were excluded from the sample since they have little need for supplemental health insurance. Hispanics may have been underrepresented for the same reason and because of language problems over the telephone. Furthermore, both groups could have been underrepresented because they are less likely to have telephones. On the other hand, younger Medicare beneficiaries might be over-represented because they are more likely to live in private residences.

Other differences, however, are more perplexing. For example, it is odd that the survey sample exhibits traits indicating both higher economic status (e.g., more education) and lower economic status (e.g., female, unmarried). One possible explanation is that respondents were less truthful about some personal characteristics (particularly education) to Response Analysis interviewers than they may be to national census takers. The reason that the survey may have overrepresented females (and therefore probably the unmarried as well) may have been that females were more likely to answer the phone and were more willing to be interviewed. Although an attempt at randomization was made by asking to interview the elderly person with the next birthday if there were two over age 65 in the household, it is possible that in some cases this request was not followed by respondents. Finally, since this sample was the result of a random selection process, some difference ffrom census figures is to be expected.

◆ The Elderly's Knowledge of Medicare Changes

One purpose of the survey was to determine the degree to which the older Americans understand the recent changes in Medicare. On one hand, their knowledge levels might be high given the extensive amount of press coverage concerning the changes. On the other hand, previous research has shown that the elderly appear to understand few of the specifics of their Medicare coverage.[5]

To assess knowledge, we asked nine questions about the recent changes in Medicare to 303 individuals: the half of the split sample of owners to whom we did not explain recent changes (N=194), and those who did not own private insurance policies (N=109). For each item, interviewers asked respondents to indicate whether the statement was correct, incorrect or that he or she did not know. The "don't know" choice was included to reduce the amount of guessing, and therefore better gauge true knowledge levels.

The nine questions (with answers in brackets) represented six primary aspects of the legislation:

- ***Hospital Coverage***
- With the new catastrophic coverage, Medicare will cover all costs of a hospital stay, except for an initial payment of about $500 [True].
- ***Physician Coverage***
- Medicare will cover all costs that your physician charges you for services [False].
- Medicare will cover all reasonable costs of physician services after the first $1,400 or so per year is paid [True].

- ***Nursing Home Coverage***
- Medicare will cover most of the costs associated with a six-month nursing home stay [False].
- ***Prescription Drug Coverage***
- When the new legislation is fully phased in, Medicare will cover some of the costs associated with prescription drugs [True].
- Medicare will pay 80 percent of all reasonable prescription drug costs during a year [False].
- ***Spousal Impoverishment***
- Medicare will provide some protection to the husband or wife of a nursing home patient to avoid loss of all of his or her assets in paying for nursing home care [True].
- ***Financing***
- All people who have Medicare will be required to contribute toward the cost of the new Medicare benefits through an increase in the monthly premium [True].
- All people who have Medicare will be required to contribute toward the cost of the new Medicare benefits through an increase in their federal tax payments [False].

Some issues are not as cut-and-dried as the questions indicate. For example, only those above the federal poverty level are required to contribute $4 a month in additional premiums; we did not believe that this nuance would affect our results, particularly because people who received Medicaid benefits were excluded from the survey. Another example concerns the nursing home benefit. Although the new legislation could, in theory, provide coverage for up to five months, the press has made it clear that the vast majority of nursing home stays still will not qualify for Medicare coverage. Finally, it is actually Medicaid rather than Medicare that provides spousal impoverishment protection under the catastrophic legislation; however, it might have been extremely confusing to explain both the Medicare and Medicaid programs in the survey process.

Table 2 shows the percentage of sample members who responded correctly to each question. Most noteworthy is that there is very little knowledge about Medicare changes. For the nine questions, the average percentage of correct answers was only 28 percent. Knowledge levels varied a great deal, however, from question to question. For example, 47

Table 2 Respondents Correctly Answering Selected Questions

Item	Percent of Correct Responses
Covers all hospital costs except deductible	34.1%
Doesn't cover all physician charges	46.5
Covers all reasonable charges after $1,400	15.5
Doesn't cover most costs of six month nursing home stay	19.1
Covers some prescription drug costs	38.6
Doesn't cover 80% of all prescription drug costs	23.5
Provides spousal impoverishment protection	18.5
All must pay monthly premium	48.5
All do not have to pay additional income taxes	8.9

percent knew that Medicare did not cover all physician charges, but only an extremely low number (9 percent) was aware that not everyone must pay more in federal taxes to finance the program.

Other findings were just as surprising. For example, despite lengthy congressional debate on Medicare's lack of coverage for long-term nursing home care, only 19 percent of respondents knew that Medicare would not cover most of the costs of a six-month nursing home stay. Many observers would claim that the centerpiece of the new legislation is added prescription drug coverage, yet only 39 percent knew that Medicare would include any such benefits.

We conducted t-tests and one-way analyses of variance (that is, statistical tests to examine whether the difference between two or more groups of people is greater than the normal variation of numbers) to determine if knowledge levels varied along a number of characteristics. We found - (with significance levels in parentheses) that those with the highest scores were younger (10 percent), married (1 percent), Caucasian (1 percent), better-educated (1 percent) and wealthier beneficiaries (1 percent). Not surprisingly, education was a particularly important determinant of knowledge. For example, beneficiaries who had attended at least some college correctly answered an average of 3.5 questions, compared to only 1.7 for those who did not finish high school. Nevertheless, the best educated of the elderly correctly answered only about one-third of the questions, underscoring how poor Medicare knowledge really is.

The elderly have formulated opinions about the Medical Catastrophic Care Act; unfortunately, these opinions appear to be based more on ignorance than facts. Given that this piece of legislation has received an unprecedented amount of press coverage — beginning with the Bowen Commission study a year before passage of the legislation and continuing to this day — it is indeed perplexing how little of this information has been assimilated.

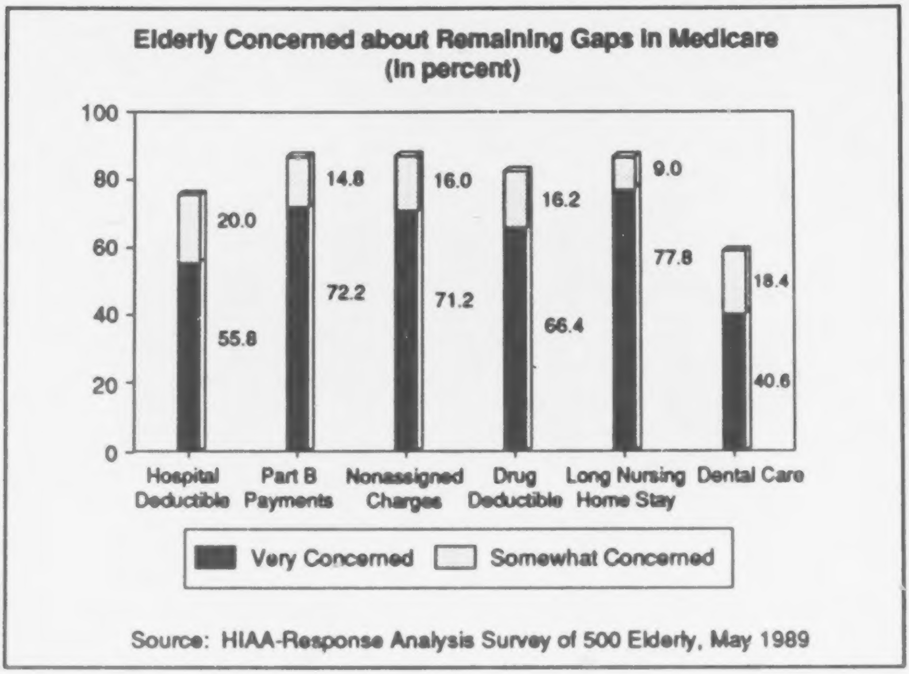
◆ Concern about the Remaining Gaps in Medicare

We asked respondents six questions regarding their concern about some of the gaps that remain in Medicare even after passage of the Medicare Catastrophic Care Act. These questions were asked of all 500 respondents. (Owners of private policies were asked what their level of concern would be if they did not have any insurance to supplement Medicare.) Respondents were given four choices: "very concerned," "somewhat concerned," "not too concerned" and "not at all concerned." The specific expenses addressed were:

- The first $560 of a hospital stay;
- The $1,400 (approximate) in Part B payments;
- Doctor bills higher than the Medicare allowed amount;
- The first $600 in prescription drug costs;
- Paying for a long nursing home stay; and
- Paying for dental care.

Figure 1 shows the proportion of respondents who were either very concerned or somewhat concerned about these expenses. The message that emerges is that the elderly are very worried about incurring any out-of-pocket costs. Stated differently, it appears that they strongly desire complete insurance coverage (i.e., with no deductibles or coinsurance), which probably explains why so few plan to drop their private insurance coverage in the wake of the Medicare changes.

Fully 73 percent said they were "very concerned" about long nursing home stays and 71 percent felt "very concerned" about excessive physician charges. Both of these expenses are unknowns and have the potential of causing great financial hardship. It is interesting that respondents also are concerned about fixed expenses that by most standards are not terribly high, especially when compared to supplemental health insurance premiums. (As discussed later, our respondents reported paying mean annual premiums of $718.) For example, 66 percent were



Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 1

very concerned about the first $600 of prescription drug costs and 56 percent were very concerned about the Part A hospital deductible.

We do not mean to imply that the elderly are mistaken in their concern — obviously, it is a subjective assessment. Rather, the picture that emerges from the findings is a group of people with a weak understanding of the Medicare program, and who appear to deal with the resulting uncertainty by desiring coverage for any remaining gaps. Concern over lingering gaps in Medicare may prompt many to retain their private supplemental insurance, an issue addressed later.

We conducted chi-square tests (that is, statistical significance tests that show whether there is a relationship in a categorical variable between two or more groups) to examine variables associated with the level of concern. The most consistent finding was that people with lower incomes tended to be more concerned about all of the remaining gaps in Medicare. For example, whereas 73 percent of those with annual incomes below $10,000 said they were "very concerned" about the $560 Part A deductible, this was true of only about 36 percent of those with incomes above $20,000. Two other consistent findings across the six "concern" questions were that younger beneficiaries were more concerned than their older counterparts, particularly with regard to long nursing home stays and that the less educated were more concerned about Medicare's gaps. We have no ready explanation as to why younger beneficiaries expressed a greater degree of concern than their older counterparts. Another curious finding was that whites expressed more fear than nonwhites about the costs of long nursing home stays, but less concern about dental costs.

◆ Attitudes about Medicare and Medicare Changes

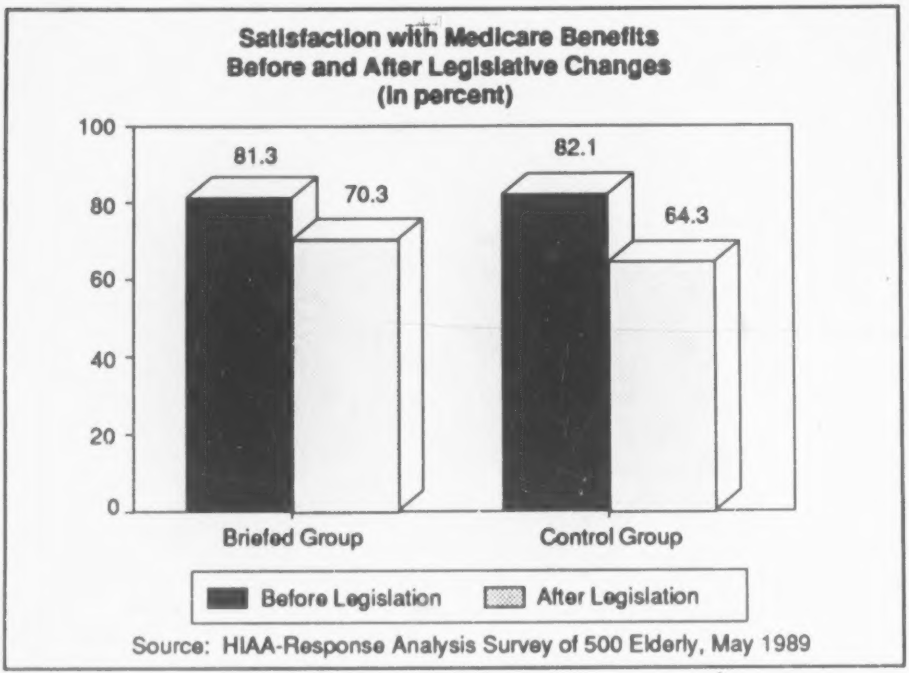
The survey measured respondents' satisfaction with Medicare benefits and costs both before and after the recent changes. Here the split-sample technique becomes important. We are particularly interested in whether those to whom we explained the changes in Medicare's benefits responded more positively than those in the control group, who did not receive an explanation of the new benefits. The results are from the 78 percent of respondents who own private insurance.

There were five questions concerning their satisfaction with Medicare:

- How satisfied they were with Medicare's benefits before the legislation was enacted;
- How satisfied they are with program benefits after the legislative changes;
- How satisfied they were with Medicare premium costs before the changes;
- How satisfied they are with Medicare premium costs and any additional income taxes they may have to pay; and
- Their overall opinion of the new legislation.

For each of the first four questions, respondents were given four choices: "very satisfied," "somewhat satisfied," "not too satisfied" and "not at all satisfied." The first two categories fit into an overall "satisfied" category and we eliminated "don't know" responses so that the resulting percentages indicate the level of satisfaction among those with an opinion.

Figure 2 shows satisfaction levels with Medicare benefits before and after the legislation passed. An unexpected finding was that among both those to whom new benefits were explained and those to whom they were not, respondents indicated more satisfaction with Medicare benefits before these benefits were expanded. In both groups, approval levels declined by more than 10 percentage points. The findings with



Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

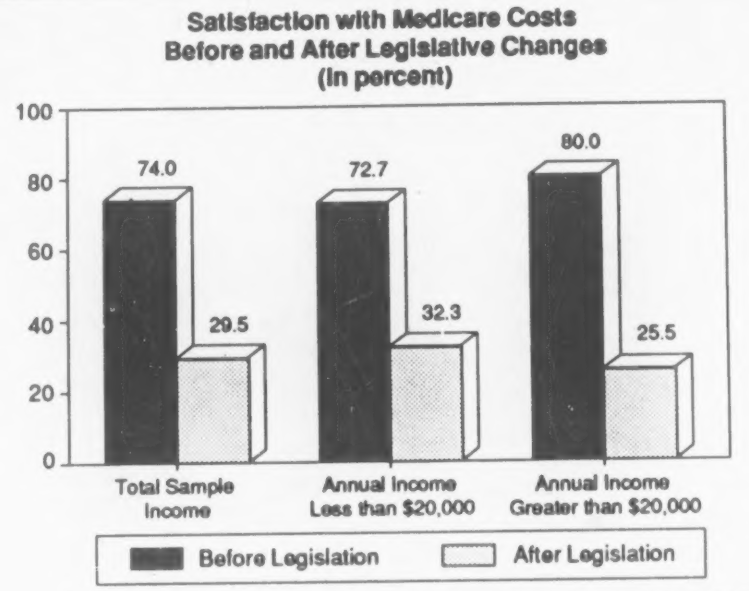
Figure 2

regard to costs are shown in Figure 3. Whereas more than 70 percent of respondents were satisfied with their payments before the legislation, satisfaction fell precipitously to around 30 percent afterwards. Furthermore, similar levels of dissatisfaction were recorded among different income levels. We believe that this strong dissatisfaction with the financing mechanism of the new law has colored the elderly's view of the benefits. This in turn might explain the anomalous result that they preferred the old, more limited Medicare benefit package.

We conducted chi-square tests to determine characteristics associated with Medicare satisfaction levels (both benefits and costs) both before and after the new legislation passed. The only statistically significant pattern was that those in fair or poor health were less unsatisfied with program costs after the new legislation (significant at the 10 percent level).

Whether most elderly people approve overall of the recent changes is an important question. To address this, we asked respondents:

> Taking into account both the benefits and costs [of the Medicare Catastrophic Care Act] to you, which of the following describes your opinion about the changes in Medicare?



Satisfaction with Medicare Costs Before and After Legislative Changes (In percent)

Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 3

> Do you (1) strongly support the changes, (2) support the changes somewhat, (3) oppose the changes somewhat or (4) strongly oppose the changes?

Table 3 presents the results for all respondents and for each of three groups: the owners of private insurance to whom benefits were explained, the control group of owners who were not given an explana-

Table 3 Overall Opinion about the Medicare Catastrophic Coverage Act

	Briefed Owners	Control-Group Owners	Nonowners	Total
Strongly Support	9.2%	6.7%	5.5%	7.4%
Somewhat Support	24.5	27.8	24.8	25.9
Somewhat Oppose	21.9	17.5	11.9	18.0
Strongly Oppose	25.0	25.8	18.3	23.9
Don't Know	19.4	22.2	39.4	24.9

tion and nonowners. Looking first at the overall results in the last column, most of those who gave an opinion opposed the legislation. Whereas 33 percent of respondents strongly or somewhat supported the changes, 42 percent strongly or somewhat opposed the changes. Furthermore, opponents were more fervent: whereas 7 percent were strongly supportive, 24 percent are strongly opposed the changes. About one-fourth of respondents did not give an opinion. Chi-square tests of significance found no significant variables associated with respondents' overall opinions of the legislation.

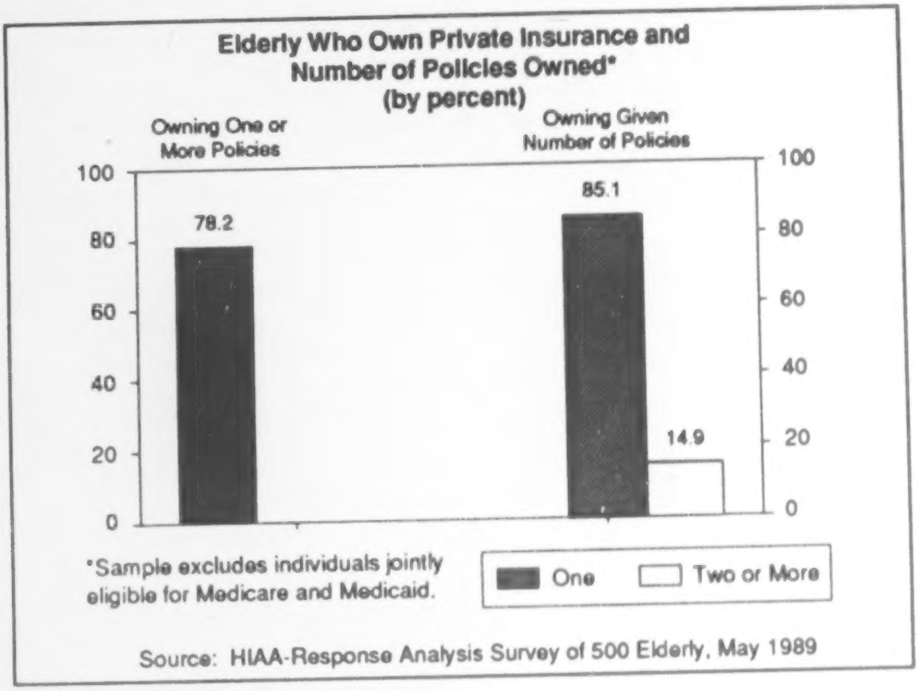
No clear pattern emerges from the split sample. When people are given information about the changes in Medicare's benefits, they do not appear to be more in favor of the legislation than do members of a control group. In and of itself, this implies that public support may not grow very much as people become more familiar with changes in the Medicare law.

◆ Who Owns Supplemental Insurance Policies

Figure 4 shows the percentage of sample members who own policies, as well as those who own more than one policy. Since individuals who are jointly eligible for Medicare and Medicaid are excluded from the survey (they typically do not buy private coverage) ownership rates are higher. We found that 78 percent of those surveyed own Medicare supplemental policies, a figure identical to estimates made by the Congressional Budget Office.[6]

Approximately 85 percent of owners said they owned one supplemental policy, with the remaining 15 percent claiming to own two or more. Only 10 sample members (2.6 percent of owners) reported owning three or more policies; one sample member claimed to own as many as six.

There have been a number of previous studies on the characteristics of policy owners and nonowners.[7] Our results are consistent with most of these other studies. We performed chi-square tests and found that the following groups were most likely to own one or more policies (significance level in parentheses): individuals age 80 and under (10 percent), whites (1 percent), married (5 percent), better educated (1 percent), higher incomes (1 percent) and those reporting better health status (10 percent). Although most of the differences were not terribly great, race was a notable exception. Whereas 82 percent of whites owned policies, only 33 percent of nonwhites did. Although those with higher incomes were more likely to own private policies, there was no relation-



Elderly Who Own Private Insurance and Number of Policies Owned*
(by percent)

*Sample excludes individuals jointly eligible for Medicare and Medicaid.

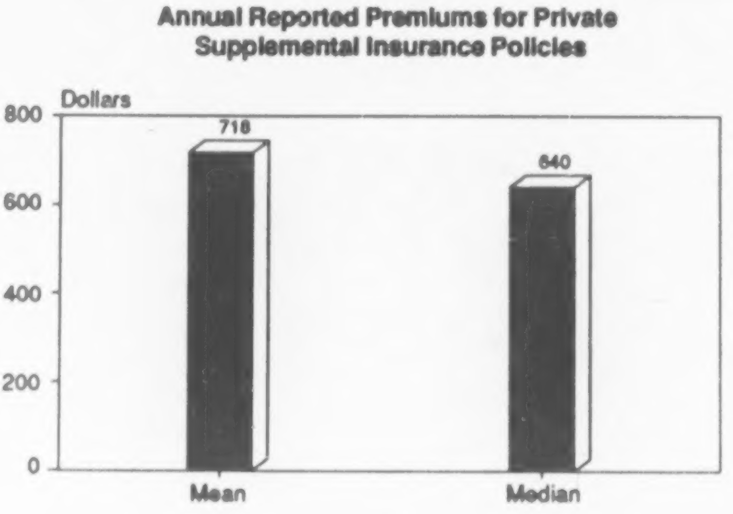
Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 4

ship between ownership and income for income levels beyond $10,000. These patterns with regard to both race and income are consistent with previous studies on the determinants of policy ownership.[8]

We also conducted chi-square tests to determine what factors were associated with owning multiple policies. The only demographic or health status measures that were statistically significant (level of significance in parentheses) were that those with higher incomes were more likely to own multiple policies (5 percent) and those who had visited the doctor more in the previous year were more likely to own more than one policy (10 percent). This latter finding may simply indicate a utilization response. People who purchase more than one policy may demand more physician visits.

The mean and median annual premiums for private supplemental insurance policies reported by respondents is shown in Figure 5. The mean was $718 and the median, $640.[9] The Congressional Budget Office estimated that the typical premium for a Medicare supplemental policy was $542 in 1987.[10] Higher figures reflect the much-publicized fact that policy premiums have risen substantially since that time.[11] We con-



Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 5

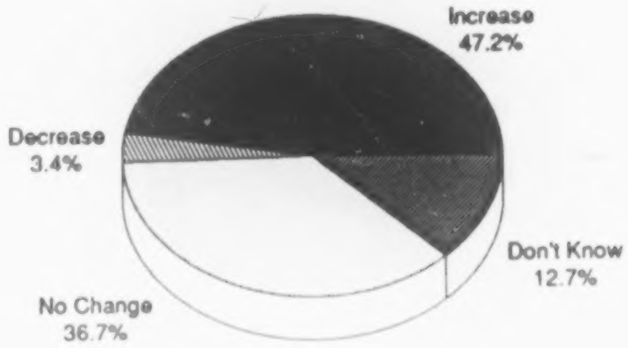
ducted t-tests on a number of individual characteristics that might be associated with higher premiums, but could find no variable that was statistically significant even at the 10 percent level.

We also asked respondents whether their premiums had increased during the previous 12 months. While respondent recall might be unreliable, particularly if the premium were being paid by an employer or former employer, we wanted to determine whether satisfaction with private policies is affected by premium increases (an issue examined later in the findings). Figure 6 shows that 47 percent of respondents indicated that their premiums increased, but 40 percent said that there was no change or that they actually decreased. Of those reporting an increase, the median was about 20 percent, or $12 a month.

Respondents were asked to indicate which of the following statements best described the policy(ies) they own (if they owned more than one policy, questions applied to the one with the highest premium):

- It pays many of the medical expenses not covered by Medicare; these are sometimes called "Medigap" or "Medicare supplement" policies;

Changes Reported in Policy Premiums During the Past 12 Months



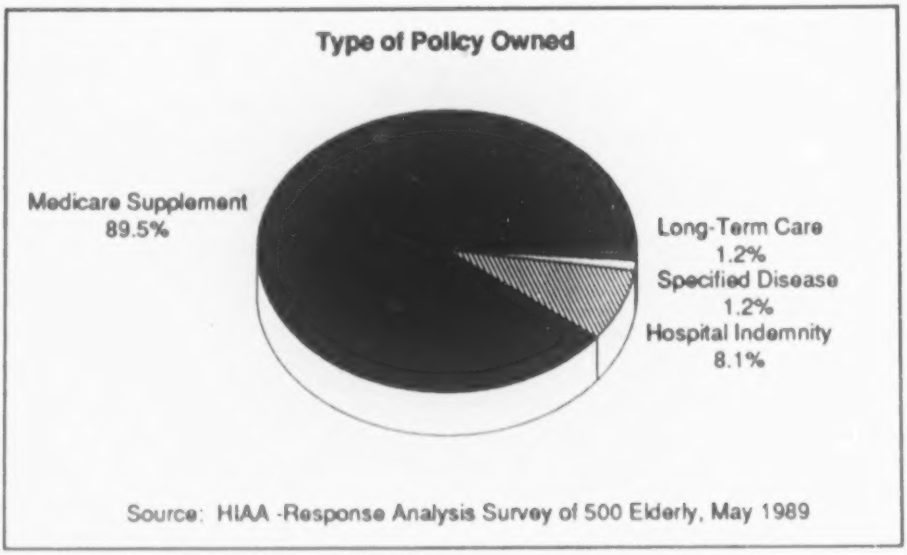
Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 6

- It pays you a fixed amount of money for each day you spend in the hospital (hospital indemnity);
- It pays only for long-term care in a nursing home or care at home; or
- It pays only if you have a specific disease such as cancer.

Figure 7 shows the responses. The large majority of policy owners (90 percent) reported having Medicare supplemental policies. The next highest (8 percent), was for hospital indemnity, while only 1 percent each reported having specified disease or long-term care policies. It is possible that the non-Medicare supplemental policies were underreported because, among those people who owned more than one policy, these policies were not their primary policy.

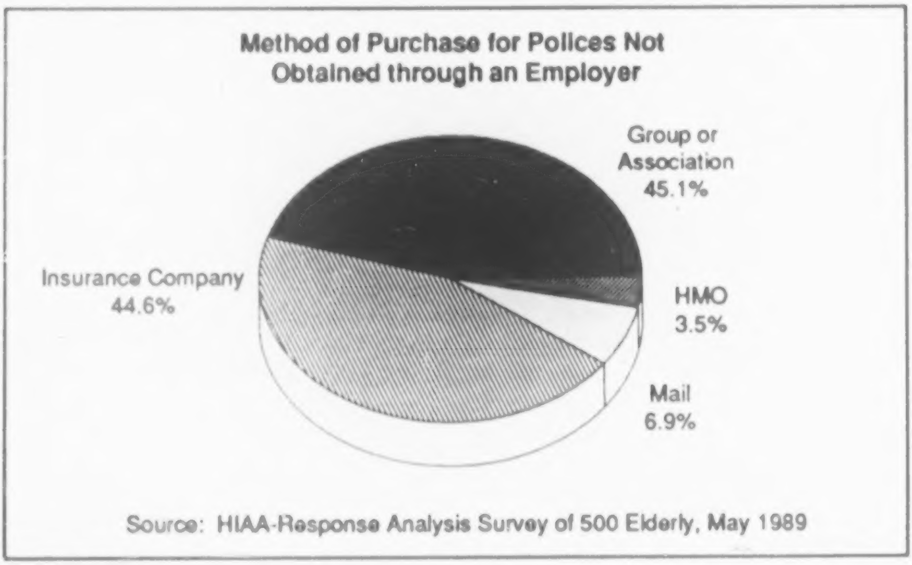
We asked those respondents who did not obtain their policies through an employer or former employer how they purchased their policies. The choices were: (1) through a group or association; (2) from an insurance company or agent; (3) through the mail, or (4) through an HMO. Figure 8 shows that 90 percent purchased policies through an association or group, or through an insurance company or agent of such a company.



Source: HIAA -Response Analysis Survey of 500 Elderly, May 1989

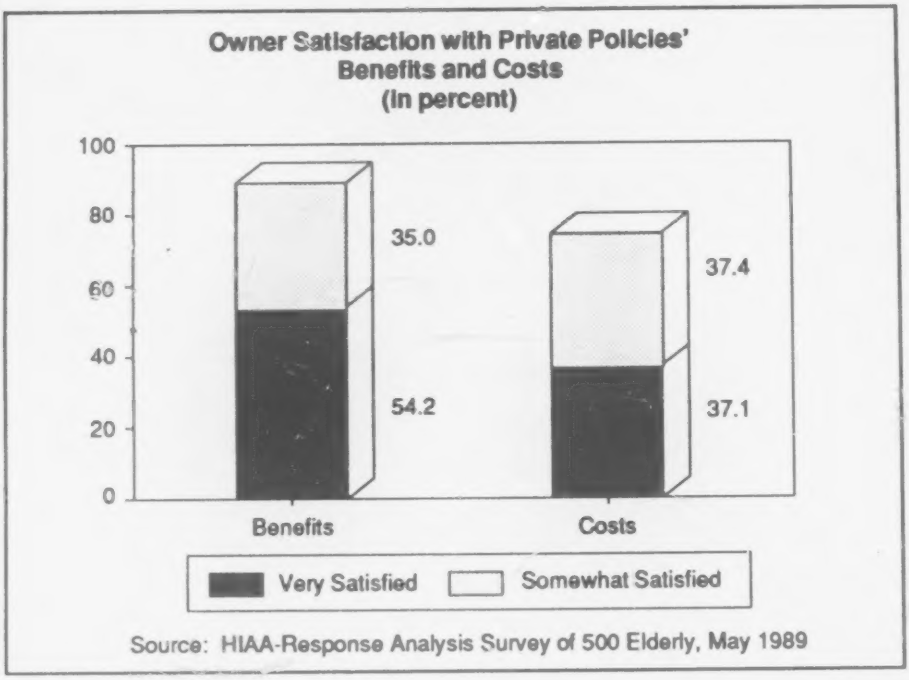
Figure 7

We also asked all respondents their desired method of purchasing a policy if they were doing it again. Not surprisingly, those who acquired their policies through an association or group preferred that method,



Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 8



Owner Satisfaction with Private Policies' Benefits and Costs (in percent)

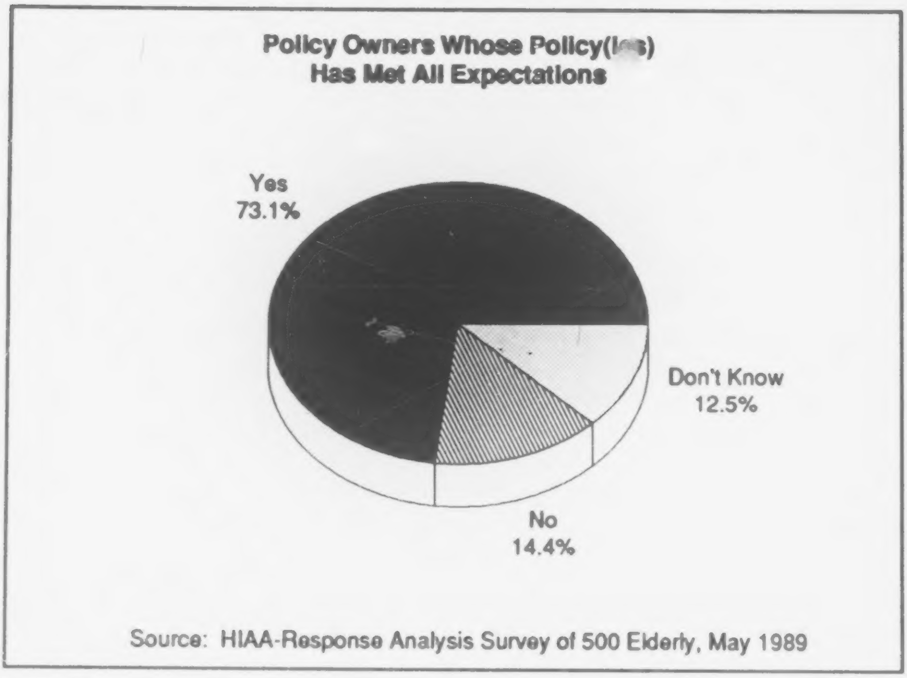
Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 9

whereas those who used an insurance company thought that was best. People who acquired their policies through an employer or former employer overwhelmingly preferred that method.

◆ Satisfaction with Private Insurance Policies

We asked policy owners several questions about their satisfaction with their private insurance policies. The first two questions concerned satisfaction with policy benefits and costs. Respondents were given four choices: "very satisfied," "somewhat satisfied," "not too satisfied" and "not at all satisfied." (Respondents who answered "don't know" have been excluded from these tabulations.) Figure 9 shows that nearly 90 percent of owners report satisfaction with policy benefits and almost three-quarters with policy costs. These figures are a little higher than the Medicare satisfaction levels before the new legislation reported in Figures 2 and 3, and much higher than current Medicare satisfaction levels. Satisfaction with costs could be associated with whether the person said his or her premiums increased during the previous 12 months. People whose policy premiums had not increased were twice as likely to be "very satisfied" with policy costs (significant at the 1 percent level).


Policy Owners Whose Policy(ies) Has Met All Expectations

Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 10

We conducted chi-square tests to determine characteristics associated with policy satisfaction, and found (with level of significance in parentheses) that high school graduates were more satisfied with both the benefits (1 percent) and costs (1 percent) of their policies. Those who said they were in only fair or poor health were less satisfied both with policy benefits (1 percent) and costs (5 percent).

Another question on the survey asked whether the respondent's private insurance policy "met all your expectations." Figure 10 shows that, for a large majority of owners, their policies did so. Almost three-fourths said that their policies met all expectations, while only 14 percent said that they did not. (The remaining 13 percent did not know, possibly because they had not yet used any policy benefits.) The most frequently noted shortcoming was physician care, followed by hospital, prescription drugs and dental services.

◆ Effects on the Private Market

One of the great unknowns about the new Medicare coverage is how it will affect the private insurance market. The legislation does remove some of the reasons that elderly persons might have for purchasing supplemental coverage. In particular, two glaring gaps in Medicare were filled by the legislation. Beneficiaries are no longer at financial risk for hospital stays that exceed 60 days and there is now a cap on their 20 percent Part B coinsurance liability. The Medicare prescription drug coverage, when fully implemented, also removes some of the risks of incurring very high levels of out-of-pocket costs.

On the other hand, the legislation falls short of covering all health care costs. There are, of course, the remaining beneficiary financial responsibilities for hospital care ($560), Part B ($1,370 plus charges above the Medicare allowed amount for nonassigned claims), prescription drugs ($600 plus 20 percent of additional costs), as well as most nursing home care. Whether these remaining gaps would be sufficient to cause the elderly to retain their supplemental insurance policies was one of the most important research questions addressed in the survey.

As before, we employed the split-sample technique, to determine if there were differences among those who were briefed about the new Medicare benefits versus those who did not receive additional information. One could argue that the former group's responses might be more predictive of the long-run response, because over time it is likely that the elderly will gain additional knowledge.

Respondents were asked one of two questions, depending on whether they said they owned one policy or more than one policy. If a respondent owned one, we asked:

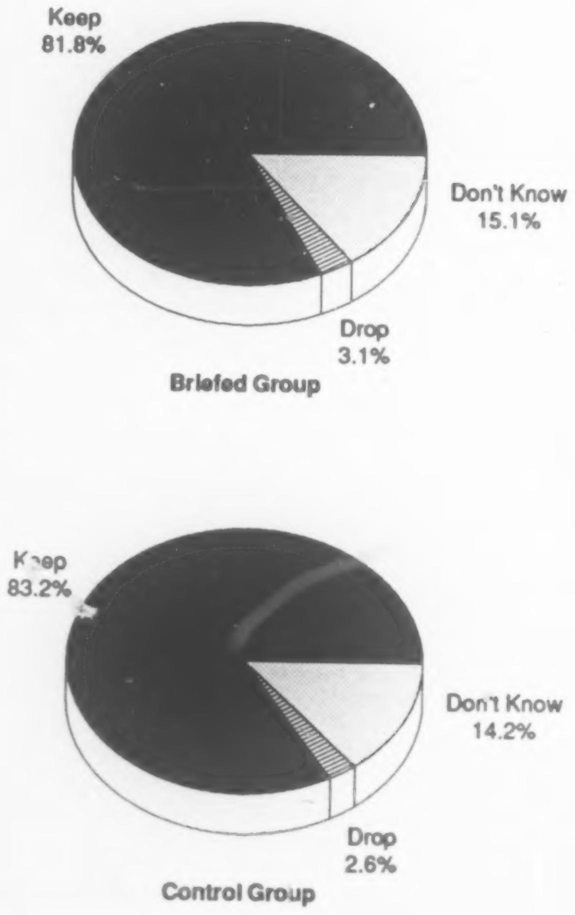
> What do you think you are likely to do once the new Medicare benefits are fully implemented? Do you plan to keep the additional health insurance policy that supplements Medicare or do you plan to drop it?

If a respondent owned more than one policy, the wording was:

> Do you plan to keep all of the additional health insurance policies you have that supplement Medicare, drop some of them or drop all of them?

We have combined answers to these questions into three categories: keep all policies; drop one or more policies; or don't know. Figure 11 shows the response for the two groups, which are nearly identical. More than 80 percent in both groups reported plans to keep private insurance policies. Only 3 percent of each group had plans to drop one or more policies and about 15 percent did not know what they would do.

Private Insurance Owners Who Plan to Keep or Drop Their Policies



Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 11

Because insurers are particularly interested in the types of policyholders who plan to drop their supplemental insurance coverage, we performed a logistical regression analysis to examine the determinants of the decision. Logistical analysis is a technique that allows one simultaneously to examine predictors of a yes-or-no variable, such as whether a person plans to keep or drop an insurance policy. Few respondents said they planned to drop their policies. Therefore, we defined the dependent variable as equal to 1 (or "yes") only if the respondent said that he or she would keep all policies and 0 (or "no") if the person planned to drop one or more policies or had not decided. Even defined this way, only 17 percent of respondents were assigned a value of zero. Predictor variables included: a variety of demographic, health status and insurance policy characteristics; a measure of concern about out-of-pocket health care costs; measures of satisfaction with Medicare as well as private insurance policies; and a variable indicating whether or not the person was briefed about changes in Medicare benefits.

Results of the logistical analysis revealed that very few factors had a significant effect on the decision to keep supplemental insurance. Perhaps most notably, those who were briefed about the new Medicare benefits were no less likely to say they would keep their policies (a finding consistent with the data shown in Figure 11, page 23). Other findings of interest were that:

- Better-educated individuals were no less likely to say they would keep their policies;
- Those most concerned about out-of-pocket costs were no more likely to say they would keep their policies; and
- Those with higher premiums and those whose premiums increased in the past year were no less likely to say they would keep their policies.

There were only three variables that were statistically significant predictors in the decision to keep a Medicare supplemental policy(ies) (significance level in parentheses). Individuals who claimed to be in fair or poor health were more likely to say they would keep their policies (5 percent). Those who originally obtained their policies through an employer also were more likely to keep them (1 percent). But individuals who said that their policies did not meet all of their expectations said they were less likely to keep them (1 percent).

This last variable had the largest overall effect on the decision to keep or drop private insurance. Table 4 shows that among the 14 percent of respondents who reported that their policies did not meet all of their

Table 4 Policy Owners Who Plan to Keep or Drop Their Policies

	Policy Met All Expectations	Policy Did Not Meet All Expectations
Plan to Keep Policies	86.5%	60.4%
Plan to Drop Policies	1.1	13.2
Don't Know	12.4	26.4

expectations, 40 percent plan to drop a policy or do not know whether they will, versus only 14 percent for those whose policy has met all expectations (significant at the 1 percent level).

Putting these findings together, it appears that the primary reason that some individuals may not retain their private insurance policies is not because of the Medicare Catastrophic Care Act's benefits, but because they are dissatisfied with the private insurance policies. One could easily imagine these people switching to another policy. Thus it appears that even though the catastrophic legislation will change the content of policies, people will continue to purchase them (although one must interpret these results with some caution as it may be too early for most people to have made final decisions about their insurance).

◆ The Appeal of Medicare Supplemental Insurance

There are four major findings that emerge from this survey of Medicare beneficiaries. First, despite the publicity that surrounded the passage of the Medicare Catastrophic Coverage Act, the elderly still know very little about the most basic aspects of the legislation.

Second, in spite of poor understanding, a large majority of the elderly have formed opinions about the legislation and most of them do not like it very much. This is also true of those who were briefed about the legislation's benefits by interviewers.

Third, the elderly are very concerned about all of the gaps that still remain in Medicare, even those that are $600 or less (e.g., the Part A and prescription drug deductibles). They appear to have a strong preference towards complete coverage with no deductibles or coinsurance. In fact, in an open-ended question, most who said they planned to keep their policies referred either to the need for additional protection or that Medicare did not cover all costs.

Finally, the elderly are very satisfied with their private health insurance policies. Few plan to drop them, probably because of their fear of any remaining costs that are not covered by Medicare. Even those who were briefed about the new Medicare benefits did not want to drop their private insurance policies.

Our overall conclusion is that despite passage of the Medicare Catastrophic Coverage Act, program beneficiaries will still purchase supplemental health insurance policies. Older Americans fear any out-of-pocket expenses that are not covered by Medicare. Insurance companies that provide dependable coverage against these expenses will continue to attract elderly buyers.

Notes

1. U.S. Congress, House, Committee on Energy and Commerce, N. Gordon before the Subcommittee on Health and the Environment, March 26, 1986.
2. T. Rice, "An Economic Assessment of Health Care Coverage for the Elderly," *The Milbank Quarterly* 65, no. 4 (1987):488.
3. T. Rice and J. Gabel, "Protecting the Elderly Against High Health Care Costs," *Health Affairs* 5, no. 3 (Fall 1986):5.
4. U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States*, 109th Ed., 1989.
5. N. McCall, T. Rice and J. Sangl, "Consumer Knowledge of Medicare and Supplemental Health Insurance Benefits," *Health Services Research* 20, no. 6 (February 1986, Part I):633.
6. See note 1.
7. For a review of the literature, see T. Rice and N. McCall, "The Extent of Ownership and the Characteristics of Medicare Supplemental Policies," *Inquiry* 22 (Summer 1985):188.
8. See note 7.
9. Premium figures do not include policies owned by individuals who worked 30 or more hours a week, since such policies are usually paid for entirely by employers.
10. S. Christensen, S. Long and J. Rodgers, "Acute Health Care Costs for the Aged Medicare Population: Overview and Policy Options" (Washington, D.C., Congressional Budget Office, May 1987).
11. M. Tolchin, "Recipients of Medicare Also Face Rise in Cost of Private Insurance," *The New York Times*, February 12, 1989.

Item 6

UNITED
SENIORS
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Scott, McLeod, Himmelberg, Mars,
Pines and Price

T. FRANKLIN WILLIAMS, M.D.
Director, National
Institute on Aging

Three Case Histories
from the Health Insurance Counseling Program Files
of the UNITED SENIORS HEALTH COOPERATIVE
for the SENATE SPECIAL COMMITTEE on AGING
in conjunction with the hearing on the
HEALTH INSURANCE COUNSELING AND ASSISTANCE ACT OF 1990
Wednesday, March 7, 1990

For more information about the
USHC Counseling Program, call
Anne Werner)
or) 393-6222
Janice Lamb)

Case #1 : Mr. and Mrs. Williams

Mr. Williams was a Federal retiree who had Blue Cross/Blue Shield for himself and his wife; they each had Medicare Parts A & B. In addition, Mr. Williams had two other Medicare supplements, an accident policy and a hospital indemnity with three riders, all of which totaled $4,913 in annual premiums. After counseling on the benefits he had through Medicare and the Federal BC/BS, he decided to drop the last three policies.

His wife, covered under Mr. Williams Federal supplement, also had an additional supplement, two accident policies, and two small life insurance policies. Mrs. Williams agreed that she did not these policies; she saved $1,074 annually by dropping the accident plans and surrendering the life policies for cash. Mrs. Williams planned to apply some of the money saved to a long-term care insurance policy. USHC counseling also enabled Mrs. W. to collect $1,800 due her in prescription drug reimbursements which she did not realize was due her under the Federal BC/BS plan.

Because the counselor was concerned that this couple seemed to be targeted by one insurance company, she wrote the state insurance department, calling to their attention the frequent number of sales calls made to Mr. and Mrs. Williams. The department did make inquiry but said it could take no action since it could not find evidence of any violation of state law.
To recapitulate:

Mr. W. saved on unnecessary insurance premiums	$4,913
Mrs. W. " " " " "	1,074
Mrs. W. cash surrender value	764
Received in drug reimbursements	1,800

Case #2 : Mrs. James

Mrs. James is a widow who has Medicare Parts A & B and at the end of 1989 she was switched from the Aetna Federal plan to Blue Cross/Blue Shield Standard Option. In addition, she had a supplement sold by a large women's membership organization (annual premium of $2,538), an in-hospital private duty nursing care policy (annual premium of $556), and a catastrophic coverage plan (annual premium of $342). She also had a long-term care insurance policy and a group accident plan which she decided to keep. After working with the USHC counselor, Mrs. James realized that the the group membership supplement, the private duty nursing care policy and the catastrophic plan provided duplicate or unnecessary coverage and dropped these three plans, thus **saving $3,436 annually.**

Case #3 : Mrs. Edwards

Mrs. Edwards came to USHC for counseling a month before she turned 65. She was paying $3,774 in annual premiums at that time for two major medical policies, a cancer policy, an HMO, and a hospital indemnity policy. She had no understanding of Medicare coverage and whether or not her major medical plans supplemented Medicare. Through USHC counseling, Mrs. Edwards realized that she could cancell all of her former policies and substitute a comprehensive Medicare supplement with an annual premium of $820. **The annual saving to her was $2,954.**

Background:

United Seniors Health Cooperative is a non-profit membership organization of more than 12,000 older people and others concerned about being wise consumers of health care. To fulfill this mission, USHC provides information through a newsletter, publications and direct one-to-one counseling.

In the past year the organization helped more than 1,500 older people make wise choices in the purchase of Medicare Supplemental (Medigap) insurance and long-term care insurance. USHC does not sell, or in any way benefit from, purchases or recommendations about purchase of health insurance. No fees are charged for the counseling service which is supported by USHC, its members and foundation grants.

From our experience we have found that a large number of people are confused about what Medicare covers, what the gaps in Medicare coverage are, and what Medicare does not cover at all. Presented below are three case histories of people who came to USHC concerned that they did not have adequate insurance protection when, in fact, they had overlapping and duplicate coverge. Although these cases are rather dramatic, they are not unusual — we estimate that approximately 23% of all older persons we counsel have at least some duplicate and unnecesary insurance.

Item 7

MEDICAL INSURANCE ASSISTANCE, INC.

1504 N. Hancock
Post Office Box 9634
Colorado Springs, CO 80932
(719) 632-1794

February 21, 1990

The Honorable David Pryor
U.S. Senate
Special Committee on Aging
Dirksen Senate Office Building, G-31
Washington, DC 20510-6400

Dear Senator Pryor:

I am extremely excited that your committee is conducting hearings relating to problems experienced by the elderly with Medigap insurances. This is indeed an area of great concern, and I trust that favorable changes will be forthcoming through your efforts.

By way of introduction, I am the Founding-Director of Medical Insurance Assistance, a non-profit agency that helps seniors with problems with Medicare, Medicare Supplementals and other health insurances. We are most cognizant of the need for this type of service and feel that it should be available in every community.

Since we feel very strongly that seniors should not have to pay to "insure their insurance," there is no charge for the service we provide. We receive Federal Funds under Title III of the Older Americans Act; we request donations from our clients and also seek funding from numerous other granting agencies and citizens in our community who are supportive of our work.

We have been most successful in our endeavor, providing service to over 12,500 unduplicated individuals since 1982 and recouping over 4.5 million dollars to help them pay medical bills. We currently help over 600 persons per month, on an ongoing basis.

We meet with our clients, one on one, to help file their claims with insurances, to follow up to assure that insurances pay according to the contracts and to help our clients determine who to pay when they receive insurance checks. In addition to those services, we explain and clarify insurance policies for our clients, helping them to make informed decisions about purchases and to avoid being over/under-insured.

Also, I teach a four-hour class in two sessions every other month to help our seniors with hands-on instruction, helping them understand Medicare, Medigaps and how to do the paperwork to collect benefits. We have not been able to get funding for this program, so it has been difficult to do it professionally. Nonetheless, it has been most effective and the feed-back has been excellent.

All of this is done with a minimum of cost and a maximum of effort. We have two paid staff persons and seven dedicated volunteers. Even at that, we find it impossible to meet the needs and often cannot provide timely service to needy clients.

I had hoped that some of our clients would be able to appear in testimony before your commission on February 27. However, that is not possible for a variety of reasons. In lieu of that, I have taken the liberty to attach some case histories that I feel might be of interest to you and your committee.

Though Medigap policies certainly have their flaws, there is a far greater problem with the Employee Group Health Insurances for Medicare beneficiaries who have group insurances through former employers. There is no uniformity in any of these insurances, and the requirements for collecting benefits are ABSOLUTELY IMPOSSIBLE. The insured either complies with all the ridiculous requests from that company insurance, or he gets no benefits to help pay his medical bills. There is gross injustice in this area, and the rip-off is beyond comprehension!

I would appreciate consideration of the following by your committee:

1) That ALL companies who insure Medicare beneficiaries be required to provide a "Disclosure Form" to the insured that outlines in UNDERSTANDABLE ENGLISH how that policy pays, secondary to Medicare.

2) That ALL companies pay benefits from the Medicare Explanation of Benefits and not require the EOMB, an itemized bill and a claim form signed by the doctor. These requirements are too difficult for most elderly to meet. Many times the person is recovering from a very serious illness, is physically or mentally impaired and cannot possible comply with the requirements of the insurance company, thereby allowing the insurance to avoid paying benefits.

3) EVERY Explanation of Benefits should have a toll-free number and the name of a person to contact who could actually give you answers to your questions and not make you feel like a case of arrested development!

4) EVERY insurance company should be given a limited time in which to pay claims or they should be required to pay interest to the insured. If the insured fails to pay premiums in a timely fashion, he loses his insurance; yet companies can procrastinate for months on end and avoid paying benefits. I often wonder about the "high cost of health care," or is it really the "high cost of inefficiency?"

In closing, I want to express my appreciation for this opportunity to air some genuine grievances. I am indeed hopeful and encouraged that these will be given consideration and that the outcome will prove beneficial for all seniors.

Thank you for your interest and concern!

Most sincerely,

(Mrs.) Betty Magninie
Executive Director

CASE HISTORIES

Mrs. L., age 68, has been undergoing treatment for cancer since June 1989. Medicare pays her claims with few errors, but her secondary insurance with Metropolitan through General Motors is impossible! Over and over again, claims are submitted according to Metropolitan's requirements, i.e., an itemized bill, a claim form and the Medicare EOB. Somehow Metropolitan cannot or will not process and pay these claims. They ask for an itemized bill or they ask for an EOMB, and if both aren't sent together (AGAIN), they cannot seem to match one to the other. Then Metropolitan states they will "not pay chemotherapy for this diagnosis," so one has to reconvince them that the diagnosis is cancer. Meanwhile, Mrs. L. owes $2,600 to her cancer doctor for chemotherapy. She does not need this stress! In addition to her life-threatening illness and the reaction she has to chemotherapy, she is extremely concerned about her medical expenses.

Mr. B's wife, age 77, was seriously injured when she fell down a flight of stairs and was in a coma for months prior to her death in November 1988. She had Medicare and Blue Cross/Blue Shield of Colorado. Three ambulance bills were sent to Medicare and should have crossed over to BC/BS. Due to some error, they did not cross over. When BC/BS finally processed these claims, the check was sent to a "Misc. Provider" at the BC/BS address in Denver. Then the BC/BS computer would not reprocess the claim because it showed "previously processed." On and on it went, and it took over a year to unsnarl those claims and collect benefits. Even though Mr. B. was not liable for this bill, he was threatened with collection over and over. The only way he avoided collection was through our constant contact with the providers.

Mrs. K, age 69, is retired from the New York transit system. She has Medicare and an impossible insurance program through her former employer. After medicare pays, her claims must be submitted as follows:

Inpatient Hospital bills and Emergency Room bills to Empire BC/BS

Outpatient Hospital bills, doctor bills (Part B charges) to Group Health Inc.

If Medicare and Group Health do not pay in full, then the bills and ALL EOB's must be sent to Travelers which is a Major Medical.

Dental bills and prescription drug bills have to be sent to a different address.

This is a good insurance program, IF YOU CAN FIGURE OUT WHERE TO SEND WHAT!

Mr. and Mrs. H., both in their late 70's, have insurance with Principal Mutual through his former employer. Both Mr. and Mrs. H are suffering from impaired thinking and currently have about $8,000 in unpaid medical bills. In an effort to determine if insurance has paid on any of these bills, several attempts were made to gain needed information from Principal Mutual. They would not release information because of the Privacy Act (and I respect that), but when we made the request in writing and provided signed authorization for release of information, we were advised that the cost for each EOB would be $25.00. It is impossible to resolve this kind of problem without communications from the insurance company.

These are not Medigap problems, but ones I would like to share with you:

Mrs R., age 79, is confined to a SKILLED CARE FACILITY, and Medicare paid the 150 days of her care in 1989. Mrs. R. is still receiving SKILLED CARE and Medicare would pay for her stay, except her 150 days have been used. The tragedy is that Mrs. R. has a Medigap policy that would pay ONE YEAR of Skilled Care if Medicare would acknowledge the 100 days beginning January 1, 1990. Since she is caught in the transition time and thus far, Medicare will not pay, it will cost her husband $30,000 this year UNLESS we can get a favorable decision from Medicare.

And finally:

Mr. and Mrs. R., ages 66 and 69, had paid his nursing home costs for more than a year. He has Parkinsons. Having spent their life savings, application was made for Medicaid. Medicaid was denied because Mr. R's income is $12.50 per month over the eligibility level. The maximum allowed is $1,104.00, and he received $1,116.50. After a hearing before an ALJ, Medicaid was still denied. How is one supposed to pay 1,960.00 per month when he receives only 1,116.50? The final outcome is that Mrs. R. filed for legal separation and requested maintenance. She receives $400.00 per month and his income is reduced sufficiently to qualify for Medicaid.

Item 8

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

OFFICE OF SERVICES TO THE AGING

OLIVIA P. MAYNARD, Director

P.O. Box 30026
Lansing, Michigan 48909
Phone: (517) 373-8230

COMMISSION
JOSEPH A. RIGHTLEY
CHAIRPERSON

March 2, 1990

The Honorable David Pryor, Chairman
Special Committee on Aging
United States Senate
Dirksen Office Building G-31
Washington, D.C. 20510

Dear Senator Pryor:

Your commitment to better assisting the nation's elderly is clearly demonstrated by your introduction of the "Health Insurance Counseling and Assistance Act of 1990". This legislative proposal has my strong support.

Although unable to be present at your hearing on health insurance issues, please accept the enclosed testimony from the Michigan Office of Services to the Aging. Our experience over the past several years, while not entirely unique to this state, will provide a view of the situations faced by at least one state unit on aging.

I hope that our remarks are helpful to you and your committee members. My staff and I remain available to provide any additional information you may require. Committee staff may directly contact Mr. Michael Bartus of this Office in this regard.

Sincerely,

Olivia Maynard

Olivia P. Maynard
Director

OPM:MFB:rd

Enclosure

TESTIMONY

OF

MICHIGAN OFFICE OF SERVICES TO THE AGING

TO

SENATE SPECIAL COMMITTEE ON AGING

"HEALTH INSURANCE COUNSELING AND ASSISTANCE ACT OF 1990"

The Michigan Office of Services to the Aging is the state agency on aging, responsible for administration of the Older Americans Act and coordination of all state activities related to the aging. Under its direct administration is a continuum of advocacy assistance programs for older persons, including legal assistance, the long term care ombudsman program and health insurance counseling services.

The Office is most appreciative of the opportunity to present its perspective on the insurance-related difficulties faced by our elderly constituency. In the remarks which follow, information is provided regarding the need for expanded health insurance counseling assistance in Michigan, our experience in attempting to mount a statewide counseling assistance program, and specific points of support for the legislation proposed by Senator Pryor--"The Health Insurance Counseling and Assistance Act of 1990".

Since 1984, the Michigan Office of Services to the Aging has devoted increased staff attention to a range of insurance issues faced by older persons. In response to consumer concerns, our efforts have focused on improved regulation of insurance practices, expanded public input in the rate-setting process, and direct assistance to older consumers who encounter difficulty in understanding and navigating the increasingly complex world of Medicare, Medicaid, long term care insurance and related issues.

On this basis of this commitment, we joined with the American Association of Retired Persons in bringing its Medicare/Medicaid Assistance Program (MMAP) to Michigan. In summary, this is a consumer-oriented health insurance education and counseling initiative, with services provided to older adults by intensively trained volunteer counselors. Over the last five years, we have refined our knowledge of the specific insurance problems faced by the older population and the family members--particularly adult children--who act on their behalf. Our case examples are enhanced by the experience of our statewide Long Term Care Ombudsman Program and local chapters of the Alzheimer's Association. We have established close working relationships with these advocacy networks, both of which are frequently the first point of access for individuals facing an insurance dilemma.

A wide range of insurance concerns have been encountered by the MMAP programs. We have reason to believe that these examples will support the premise that there is indeed a range of unresolved problems which warrant increased action at the state and federal levels.

- A 74-year old woman contacted our counseling program, the proud but confused owner of eight insurance policies. Six of these policies were Medicare supplemental policies, with benefits only paid by the Blue Cross/Blue Shield policy which had been her first purchase. An additional component of her insurance portfolio was a disability policy, clearly unnecessary for a retired elderly individual. With counseling assistance, this older consumer reduced her coverage to three policies.

- Disabled individuals under 65 years of age frequently receive Medicare benefits. All is not always well, however, as evidenced by the case in which a disabled veteran who contacted the MMAP counseling program in tears. His disability was severe: blindness in one eye, no use of one arm and only limited use of one leg. This 63-year old gentleman, while covered by Medicare, was also purchasing major medical coverage from Blue Cross and Blue Shield. Neither insurer was aware that he was fully covered by the other, no one had informed him that he did not need to purchase major medical insurance, and his out-of-pocket insurance costs were a major problem. He could no longer afford to remain in his current residence, but he had insufficient cash to afford a move. The persuasive volunteer insurance counselor assigned to this case convinced both Blue Cross and Medicare that a significant error had been made. A successful outcome was negotiated for the client, with Blue Cross and Blue Shield refunding all his premiums for a two-year period, with the subtraction of what he would have paid for the appropriate Medicare supplemental policy. The check for over $2000 enabled him to at last move into affordable residential quarters.

- Upon retirement, a married couple in their early seventies had enrolled in a Medicare risk contract health maintenance organization for Medicare beneficiaries. They later decided to withdraw from this plan and purchase a traditional Medicare supplemental policy. The health maintenance organization and the supplemental carrier each denied that they were responsible for paying covered benefits, claiming the beneficiaries were insured by the other insurer. This situation continued for two years, with the couple taking great lengths to resolve the problem. It was not resolved, medical bills were not paid by either insurer, and the couples's respective physicians informed then that they could no longer continue to provide medical services. It took six months of unrelenting effort on the part of the MMAP counselors to remedy the situation, but the case was successfully resolved.

- An elderly female Medicare beneficiary required prescription of a liquid nutrient, covered by Medicare only when prescribed and purchased in specific quantities. She was most upset when Medicare denied the submitted claims, stating that the amounts of the nutrient were insufficient to trigger coverage. A MMAP counselor became involved and assisted the client in successfully appealing the denial, resulting in approximately $20,000 in benefit coverage for the older consumer.

Beyond these specific examples, there are several areas of frequent confusion and misinformation. At a very elemental level, there are still Medicare beneficiaries in our state who believe Medicare pays their drug expenses when, in fact, the payor is their employer-provided supplemental policy. An unacceptable number of our elderly population does not know what benefits are provided by Medicare and cannot accurately read an Explanation of Medicare Benefits form. Many older Michigan residents do not understand the financial significance of a physician not accepting Medicare assignment. In the case of cataract surgery, for example, fees can be as high as $1400 more than the prevailing rate Medicare uses in establishing the approved charges. Our older residents are woefully uninformed regarding the appropriate role of long term care insurance and its relationship to Medicaid in covering long term care costs. Most senior citizens are not aware of how to exercise their consumer rights through the Michigan Insurance Bureau, frequently requiring the assistance of a MMAP counselor to begin a formal complaint and investigation process.

A frequent focus of complaints to the state's insurance regulatory agency is questionable sales practices on the part of agents. High-pressure sales tactics on the door-step of one's home, sales of disability and pregnancy riders to individuals in their eighties, and agent misrepresentation of a policy holder's pre-existing health conditions are not uncommon in Michigan. Our experience has also indicated that some agents have used the elderly individual's fear of poor health as the motivating factor in closing sales on other types of policies which are clearly not health insurance.

"Nursing homes are unbelievably expensive...what about my house, other assets...I just don't understand any of this!" With increasing regularity, we hear such statements from all parts of the state. The fastest growing area of inquiry to the Michigan Long Term Care Ombudsman Program relates to financing institutional long term care. Federal spousal impoverishment provisions and the subsequent state Medicaid implementation process have led to immense public confusion. As state level policy changes are issued--often on a monthly basis, it has been necessary for the Ombudsman Program to revise its consumer guide on Medicaid eligibility for nursing home residents. The program has now issued its fourth edition of this document, designed to answer frequently asked questions regarding Medicaid eligibility and spousal income/assets protection. Despite the availability of such a document, the general public and health care professionals remain confused over eligibility matters. It is clear that additional training of insurance counselors and expanded public education are necessary on this front.

We hear similar concerns from local chapters of the Alzheimer's Association. A significant number of questions come from the victim's spouse or other family caregiver regarding Medicaid eligibility, allowable assets and protection for the spouse residing in the community. Questions also surface regarding Medicare coverage of nursing home care, optimal cost/payout benefit from various available Medicare supplemental and long term care policies, appealing Medicare and private insurance claim denials, insurance coverage of respite and adult day care, the effects of pre-existing conditions on purchase of private health insurances, and the matter of age restrictions imposed by specific policies.

Our Michigan Medicare/Medicaid Assistance Program (MMAP) is a necessary first step in responding to these growing insurance-related concerns. The program is co-sponsored by the American Association of Retired Persons,Area Agencies on Aging Association of Michigan, Blue Cross and Blue Shield of Michigan, and the Michigan Office of Services to the Aging. Basic counseling and education services are provided by over 200 trained volunteers, with services available at accessible community sites, by telephone, and through home visits. Sixteen of the counseling sites are located in hospital settings. In 1989, we were able to serve approximately 4600 individuals through operation of the Michigan MMAP.

The major structural issue faced by this program in the last year was establishment of a state-level MMAP Staff Coordinator position. Primary responsibilities of the individual hired are conduct of structured training programs for the volunteer counselors, development of new local MMAP projects, and provision of technical assistance to the counselors on difficult cases.
As the program had evolved since 1984, we were painfully aware that the volunteers could not continue in their difficult tasks without this type of support. Most local MMAP projects received some degree of staff assistance from local co-sponsoring organizations, primarily area agencies on aging. This in-kind contribution, in the form of staff time and clerical support, was voluntary on the part of area agencies; no state or federal funds were available for the addition of staff at the area agencies on aging.

Funds were also insufficient through our office to totally support the MMAP Staff Coordinator position. Mandated federal reductions of our Older Americans Act allotments and anticipation of state budget cuts clearly limited the extent of our potential funding contribution. We are fortunate that the Charles Stewart Mott Foundation and Blue Cross and Blue Shield of Michigan recognized the critical importance of expanding this initiative. These organizations have joined us in providing the financial support for the state-level staff position. In-kind support services, including telephone, printing, postage and office space are contributed by this office, Blue Cross and Blue Shield, and the Area Agencies on Aging Association.

While these types of support have enabled us to move ahead, the staffing component is not assured of complete funding for fiscal year 1991. We will attempt to secure additional corporate and foundation support for the coming year, but we will still be left with a part-time MMAP Staff Coordinator and limited funds for travel and training purposes. The program structure and funding level proposed in the "Health Insurance Counseling and Assistance Act of 1990" is optimally suited to our situation. As written. this legislative proposal would allow continuation of our present structure and provide desperately needed support for training events designed for volunteer counselors. In addition, we could assure a financial base for staff at the area agency level--an impossible outcome without the availability of support proposed in this legislation. Finally, we strongly support the establishment of a national resource center responsive to the health insurance information needs at the state and local service delivery levels.

We do suggest, however, that you give due consideration to potential use of program services by adult children of Medicare beneficiaries and health care professionals who have care coordination responsibilities. In Michigan, our experience has been that an increasing number of information requests originate with adult children who have assumed a major role in planning of their parents health care and insurance arrangements. We also receive questions from health and social services providers who function as care managers or care coordinators. The commitment of such individuals, family member or health professional, is to be commended. Our recommendation is that at least family members, acting on behalf of a Medicare beneficiary, can obtain services from the proposed national network of health insurance counseling programs.

We feel that we have made significant progress over the past two years in coordinating the advocacy assistance resources under our purview, including the Long Term Care Ombudsman Program, legal assistance services, and health insurance counseling services. We are at the point where cross-referral mechanisms have been refined and positive working relationships are in place with the Medicare fiscal intermediary for Michigan. We are committed to agressively maintaining and expanding the extent of private sector financial support of our current program. We are ready to efficiently and effectively make use of proposed federal support in expanding Michigan's commitment to our older health consumers. We offer our strong support for your progressive proposal to assist Medicare beneficiaries in optimal deployment of their health care insurance resources.

Olivia P. Maynard, Director
Office of Services to the Aging
Lansing, Michigan
March 2, 1990

Item 9

HICAP
HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM ASSOCIATION

TESTIMONY BEFORE SENATE SPECIAL COMMITTEE ON AGING

MARCH 7, 1990

This testimony is being presented on behalf of the Health Insurance Counseling and Advocacy Program (HICAP) Association. The HICAP Association is made up of 24 programs funded by the California State Department of Aging Health Insurance Counseling and Advocacy Program (HICAP). HICAP is committed to providing assistance and guidance to Medicare beneficiaries with Medicare (including billing and claims), Medicare supplemental insurance, long term care insurance, health maintenance organizations, and other related problems and issues. Thousands of older Californians receive counseling and advocacy services through the efforts of hundreds of HICAP program staff and dedicated volunteers.

The HICAP Association is thankful for the opportunity to provide input at this hearing. The Association hopes that by offering testimony on the experiences of our member programs the Senate Special Committee on Aging will acquire some insight into the need for a national program to provide Medicare and health insurance information such as the one proposed by Senator Pryor.

For most senior citizens, paying the bills for health care would be unimaginable if not for the coverage provided through the Medicare program. However, the Medicare program is not without problems. By its very design, Medicare presents seniors with a baffling array of rules, regulations, and requirements. In addition to the problems created by the Medicare program, many seniors also confront the bewildering market of private insurance designed to cover some of the share of cost Medicare requires the beneficiary to pay. The intent of this testimony is to examine Medicare and the private supplemental insurance coverage options from the perspective of advocates and beneficiaries to demonstrate the importance of establishing a centralized source of beneficiary information assistance.

Many of the difficulties beneficiaries experience with Medicare stem from the very structure of the program. Medicare, for reasons that may have made sense when the program was started, is divided up into two parts: A - hospital; B - medical. Adding to the complexity, each part of the program has different eligibility standards, cost sharing requirements and appeals processes. Furthermore, in many parts of the country, Medicare contracts with two separate private insurance companies to handle claims processing for A and B. For some seniors, the program is so difficult to decipher they never receive the full range benefits to which they are entitled. In some instances, unraveling this tangled and confused system can be so troublesome that beneficiaries end up sicker as a result. Those individuals responsible for designing Medicare could not have envisioned the impact such a convoluted and disjointed program would have on the individual beneficiary.

One example of how the Medicare system can impact the beneficiary is the story of Mrs. B from Pasadena, California. Mrs. B was 80 years old and considered herself to be a healthy person, when in the spring of 1989 she experienced a fall in her apartment that left her with severe injuries requiring she be hospitalized for three weeks. While in the hospital she underwent surgery and upon discharge was sent to a skilled nursing facility to receive physical therapy.

When Mrs. B was finally sent home she was physically weak and emotionally depressed. Her mobility was limited to shuffling from room to room of her tiny apartment on a pair of crutches, this was physically strenuous and painful. However, the physical strain and pain could not match the emotional strain and pain she would experience when the bills started coming in the mail. Mrs. B had been a school teacher in South Carolina for much of her life, but her years of professional experience did not prepare her to deal with the onslaught of bills that resulted from her accident and subsequent treatment.

Mrs. B had no family nearby and she was not sure who to turn to for assistance. There were so many bills from so many different providers that she felt overwhelmed. She could not remember having ever sent claims to Medicare before and she was not sure where or how to begin. She made a few telephone calls, but it seemed everyone wanted to pass her off to someone else. She worried so much that she began having difficulty sleeping and eating.

Frustrated and frightened, Mrs. B finally called her local senior citizen center for help. Luckily, the center had a HICAP volunteer available to help. When the HICAP volunteer first met with Mrs. B at her home she was alert but very distraught. She had bills for over $5,000 from various providers and a bill for $3,000 from the skilled nursing facility. Mrs. B spent three home visits and several hours with the HICAP volunteer organizing bills, calling providers, making photo copies, filing claims, confirming payments, etc. When the HICAP volunteer was finally finished, all bills had been accounted for and Medicare payment was being sought for Mrs. B's skilled nursing facility stay (a benefit Mrs. B was not aware Medicare covered).

When it was all over Mrs. B's sense of relief was clearly evident. Unfortunately, while Mrs. B was lucky to receive help with a difficult situation, many thousands of seniors with similar problems do not. Mrs. B's problems profile the double bind created by the overwhelming complexity of the Medicare program. That is, when senior citizens are ill or recovering from an illness and in the worst condition to deal with Medicare bills and claims that is precisely the time at which they must.

While Medicare can present beneficiaries with many difficulties, those difficulties are often compounded when private Medicare supplemental insurance is added to the equation. Because Medicare does not offer comprehensive coverage, it leaves "gaps" for the beneficiary to fill. By far the most popular method of filling the gaps is through the purchase of Medicare supplemental insurance policies, known as "Medigaps". It is estimated that two out of three senior citizens carry one or more Medigap policy. However, selecting a Medigap policy is no easy task considering the dozens of companies marketing multiple policy options. It is a billion dollar industry. Unfortunately, much of the insurance industry profit is reaped at the unfortunate expense of older persons. Too often, policies are purchased in ignorance, fear, or due to the sale pitch of an over zealous sales agent. Past research at the HICAP program in Los Angeles County (The Medicare Advocacy Project) indicated that of the seniors they counsel over 90% have inaccurate notions of what a Medigap policy is designed to cover.

Fortunately, many of the Medicare beneficiaries come to HICAP representatives for information and assistance before they purchase Medigap insurance. In this way HICAP is able to provide the information necessary for seniors to make an informed decision. All too often, though, HICAP encounters seniors that have made misinformed choices or have unrealistic expectations with regard to supplemental insurance coverage. This misinformation and false expectations can frequently be attributed to one or more of the following three factors:

1. an incomplete understanding of the Medicare program;
2. misleading advertising or sales agents;
3. confusing policy language.

Because Medigap insurance products "track" the language and decisions of the Medicare program, in order to fully understand Medigap insurance seniors must first understand the Medicare program. A good example are the rules regarding Medicare assignment. For instance, Medicare part B pays 80% of the "Medicare approved amount". Typically, Medigaps pay the remaining 20% of the approved amount. If a physician or provider refuses to accept the Medicare approved amount they may collect charges above the Medicare approved rate from the beneficiary. Very often, seniors are under the impression that their Medigap will pay for any difference between Medicare's payment and the doctor's charges, which in most cases is not true.

Even if a senior citizen understands the Medicare program completely, they must then fend off the bombardment of direct mail, media advertisements and the sales pitches from insurance agents. Many of these solicitations can be extremely misleading. They prey on fear of a lengthy illness and exaggerate the limitations of Medicare. Many times important facts necessary to put the information into proper context are omitted. Many of the mailers and television advertisements hammer home the out-of-pocket expense for hospital stays beyond Medicare coverage. However, the average length of stay in a hospital for Medicare beneficiaries is about 7 days, far short of Medicare's 60 days of full coverage. Even if a senior citizen decides to make an informed decision by reading the policy for themselves, too often, the language of the policy is vague or cumbersome.

The HICAP agencies come in contact with many problems in the area of Medigaps. For example, Mrs. M a widow and HICAP client. She was contacted by an insurance agent who wanted to come to her home and tell her about his Medigap insurance. She told him she already had insurance and would be busy that day. As she was preparing to leave her home the insurance agent showed up. She became somewhat flustered and uncomfortable, she didn't want to be impolite but she was in a hurry to go about her business. In her words, "he was very pushy so I told him he could come in for a minute". Once in Mrs. M's home, the agent began to tell her about his insurance.

She told the agent that she already had two policies, one she received at no cost as a retirement benefit and one for which she paid very little. Both policies where part of Mrs. M's retirement benefits. The agent dismissed her policies without even looking at them saying "these aren't any good ....they don't compare to my policy which provides 100% coverage ....you should cancel them". At this point, Mrs. M became very upset and was willing to do anything to get the agent to leave. She told the agent she would purchase the insurance. She made out a check for over $800, an entire year's premiums. She told the HICAP counselor later that she was just relieved to see the agent go. Later, she started thinking about what had happened and decided to consult a HICAP counselor about her new "100% coverage" policy. After Mrs. M and the HICAP counselor reviewed her new policy and compared it to the two policies she already owned it became apparent she had been *ripped off*. The policy she had purchased from the "pushy" agent was not a 100% policy, in fact it did not even cover the first day hospital deductible (part A). Her other two policies, for which she paid very little, provided substantially better coverage than the policy she had just purchased. Furthermore, Mrs. M was now overinsured. Luckily, she came to a HICAP counselor before she cancelled her old coverage. After talking with a HICAP counselor, Mrs. M decided she did not want the new coverage. The counselor assisted Mrs. M in getting her premium returned and subsequently filed a complaint with the California Department of Insurance.

SUMMARY

The cases of Mrs. M and Mrs. B presented in this testimony are real people. Their experiences dramatize the problems older persons experience when dealing with Medicare and Medicare supplemental insurance. However, Medicare and Medigap issues represent only part of the universe of problems senior citizens confront when dealing with the present health care system with its confusing mix of public and private insurance. New health care insurance and service options for senior citizens are being introduced all around the country. For example, in California the proliferation of Medicare health maintenance organizations (HMOs) and the rapid increase in the number of long term care insurance products has created new categories of problems for beneficiaries.

Men and women who have given so much to this country are now being asked to struggle with confusing bureaucratic impediments and overwhelming private insurance choices. Our nation should take a profound interest in the way the Medicare system is treating our older citizens. Undoubtedly, the Medicare program needs to be simplified and improved. However, older persons need to have a reliable source for accurate, consumer oriented information and assistance when they have difficulties with Medicare or supplemental coverages.

Item 10

AARP

90 M[illegible] 10:37

March 14, 1990

The Honorable David Pryor, Chairman
U.S. Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, DC 20510

Re: Comments related to a bill being introduced by Senator Pryor before the Senate Special Committee on Aging, to be entitled the "Health Insurance Counseling and Assistance Act of 1990"

Dear Senator Pryor:

My name is Elizabeth C. Goodwin. I live in North Little Rock, Arkansas. I am the Arkansas Assistant State Coordinator for the Medicare/Medicaid Assistance Program (MMAP), a beneficiary counseling program sponsored by the Health Advocacy Services of AARP. While I am associated with AARP and the MMAP program as a volunteer, the comments herein are being submitted as an individual and do not reflect an official AARP position on any specific beneficiary counseling service legislation.

I wish to point out that the proposed supplemental health insurance counseling service, as outlined in the draft bill I have reviewed, is already operational in the State of Arkansas. The AARP-sponsored MMAP program was established in Arkansas in March 1987. Currently, we have MMAP counselors around the state with organized counseling sites in Little Rock/North Little Rock, Harrison, Springdale, Arkadelphia and Hot Springs. Two additional training classes will be held later this spring in Jonesboro and Batesville, with further trainings scheduled for later this year. Each of the above sites is being cosponsored by the local Area Agency on Aging (AAA) except for Arkadelphia, which is cosponsored by the local AAA and Henderson State University. We have found that working with the AAAs provides vital support and stability to MMAP in the community -- this is networking at its best.

MMAP volunteer counselors are trained together with AAA personnel and by the end of the initial three-day training, the volunteers are more aware of what an AAA does, and the AAA contact persons have someone (i.e., the counselor) to whom they can refer clients when MMAP assistance is needed. The MMAP counseling is designed to ensure that older adults receive the most from their health care dollars.

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

Louise D. Crooks *President* Horace B. Deets *Executive Director*

MMAP volunteers are organized and trained to counsel the elderly on the following:

- General Medicare information
- Filing Medicare and supplemental insurance claims
- Appealing Medicare payment decisions
- Qualifying for Medicaid and making appropriate referrals, especially regarding the Medicaid Buy-in (QMB) and spousal impoverishment issues
- Referring clients to other appropriate agencies as needed

Volunteers also provide information on how to analyze private health insurance benefits and options including Medigap, long term care, hospital indemnities, and specific disease policies. The volunteers do not recommend the purchase or cancellation of any insurance plans, but rather help the beneficiaries learn more about what they have and what their options are. Therefore, all decisions are up to the beneficiary.

Each MMAP is tailored to the needs of the community in which it is based. Site locations may be the AAA office, a senior center or a local community center. Much of the counseling is done in homes, churches, and before and after chapter or social meetings. In general, we have found that many of our clients are aging senior citizens with little or no support system.

Many older senior citizens we serve are over 75 years of age and never dreamed they would outlive their relatives and friends. They now find themselves unable to cope with the frightening days ahead of them -- not enough money, not enough strength to properly care for themselves, and not enough financial know-how to manage their money or spend it wisely. This is why we find so many individuals with several supplemental health insurance policies. They know little of the Medicare system and how it works. They are constantly being subjected to fear tactics by media ads which only add to their confusion. Sometimes, the only mail they receive is insurance solicitations and their few social visits are often from insurance agents. Many elderly are lonely, afraid, and understandably worried about their future. They have no idea where they will spend their final days, and this is of great concern to them.

These older Americans pay the insurance premiums out of their savings accounts and are frequently forced to cut down on food and even go without medicine in order to meet the premiums. This is all done in the belief that they are protecting themselves from prohibitively high medical and nursing home costs.

Supplemental health insurance counseling services are sorely needed and must include educational programs on Medicare benefits. Such programs should be expanded and made available to every person under the Medicare system, reaching from the depths of the inner cities to the outermost rural areas. We owe it to these people. We owe it to ourselves.

In conclusion, counseling programs work. MMAP works in Arkansas. MMAP works in 35 other states and several states sponsor their own program. The counseling service requires patience and should not be performed hastily. That is why carefully trained volunteer counselors in each community are so right for the program.

Sincerely,

Elizabeth C Goodwin

Elizabeth C. Goodwin
Assistant State Coordinator
Health Advocacy Services

cc: Marty Corry
Tom Nelson
Bob Jackson

Item 11

Legal Center/HICAP
Health Insurance Counseling And Advocacy Program
P.O. BOX 2547 SACRAMENTO, CA 95812
(916) 442-3486

UNETHICAL INSURANCE SALES TO THE ELDERLY

The following examples involve the same agents and agency:

EXAMPLE NUMBER 1

An 82 year old man, who is senile, was sold 19 policies for an annual premium of $6,816.11. Agents went back and sold him 9 more policies for which he wrote a check, which bounced. These agents then went back and had the man sign a loan to pay off all the premiums, giving his mobile home as security, through a savings and loan in Arizona. Because of his senility, this man did not understand or realize what he was doing. Because he ignored payment request from the savings and loan, a foreclosure notice was issued. Fortunately, the mobile home was not in his name.

EXAMPLE NUMBER 2

An 86 year old woman, with Parkinson's Disease, was sold 4 duplicate policies with an annual premium of $5,600.00. The agent "white sheeted" her applications with no mention of her medical condition. Her son has asked for action to prevent the agent from contacting his mother.

EXAMPLE NUMBER 3

A 96 year old woman was sold 13 medigap and long term care policies for an annual premium of $11,328.00. She was also sold a single premium life policy "to protect her estate" for a premium of $78,389.73. Fortunately, this life policy was cancelled.

NOTE: ALL ABOVE CASES INVOLVE THE SAME AGENT(S)

CASE EXAMPLE FOR MONTHLY REPORT

FEBRUARY 1990

Mr. B, a sixty six year old man who resides in Santa Cruz county, came to our program for assistance with his bills after a recent open heart surgery. He presented a large stack of papers that he said he had been working on since his surgery. He said that no matter how hard he tried he couldn't seem to concentrate well enough to take care of his papers.

He was especially concerned with bills that were in collection or threatened with collection efforts. We isolated those bills and calls were made to each provider apprising them of our involvement. Collection efforts were suspended by all but one doctor. A call to the hospital where the doctor performed the surgery resulted in suspension of those collection efforts after a request from the hospital to the doctor.

Mr. B left his papers to be sorted and the next step determined. There were a total of 59 checks totalling $6,084.75. Twenty six of those checks were older than six months and too old to deposit. Those checks were returned to Medicare and Blue Cross with a request to reprocess and reissue. The remaining 33 checks were matched to the bills and distributed to the appropriate providers. There were thirty three checks totalling $4,837.44 that providers received as a result of the assistance provided to Mr. B.

The stale dated checks and those services that had not been paid by Medicare and Blue Cross will also be distributed when Mr. B receives them and returns for that assistance.

Source: Annual Report FY 1988-89, HICAP.-

D. CASE EXAMPLES (ANECDOTES)[2]

Local HICAP Counselors work with seniors who face a variety of problems in paying for and obtaining health care, whether as a result of Medicare policies or the limitations to health insurance. The best way to show this variety is to provide examples of actual cases. The following are anecdotes describing actual cases, although names or other identifiers have been changed to protect the confidentiality of the clients.

- A Spanish speaking couple in Southern California were referred to HICAP after having been pressured into joining a Health Maintenance Organization (HMO) by an aggressive marketing representative. The representative told the clients they could cancel the membership by phone. The couple signed the enrollment form, primarily to disengage from the representative, believing they could call the next day and cancel. The following day they called to cancel their membership in the HMO.

  The couple continued to use their non-HMO providers. When Medicare started to deny claims, they realized the HMO had not cancelled their membership. They tried three more times to disenroll, but only after the intervention of a city councilman did the HMO finally disenroll the couple. By that time the couple was liable for $26,000 worth of unpaid claims. The HICAP intervention used a bilingual Counselor who assisted the couple in their appeal. The appeal was successful and the HMO ended up paying the $26,000 in out-of-plan claims.

- HICAP Counselors in a mid-State county helped two couples cancel Medicare supplement insurance policies sold to them by the same insurance agent. It appeared the agent may have used unethical sales tactics in selling the policies. The HICAP Counselors were also able to have the clients reinstated with their previous insurer, with no new waiting period for pre-existing conditions. The total reimbursement recovered for these clients was $3,939. In addition, the Department of Insurance began investigating the sales practices of the agent involved as a result of HICAP's intervention.

- An 83-year-old client bought a Medicare supplement policy for which she paid a full year's premium of $990. The policy was issued by the agent to her the same day she completed the application and paid the premium. Within the 30-day "free look" period, the client decided she did not want the policy and returned it to the company with written notice that she wanted to cancel.

  Subsequently, the company issued her a refund check, but only in the amount of $90. Several attempts to contact the selling agent were unsuccessful. A HICAP Counselor assisted the client by writing to the insurance company and to the Department of Insurance. The full refund check in the amount of $900 was issued to the client and delivered by Federal Express mail within six days of the letter sent to the Department of Insurance.

- In a sales presentation, an agent told a woman that her new Medigap policy would cover her while living abroad. The policy, however, did not cover her while she was out of the Country. Through HICAP's intervention, the HICAP Counselor arranged to have the agent refund the premium for the period of time she would be out of the Country ($495). After consulting with the HICAP Counselor, the client also decided to drop a "Medibill" service (a private service that takes care of billings for a fee) at an annual savings of $195. The Counselor was able to provide the necessary forms and instructions to allow the client to handle her own bills and claims.

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[2] These stories are compiled to exemplify the type of problems faced by and resolved by HICAP projects. Each year, new anecdotes are provided to reflect work conducted in the reporting period; however, some anecdotes are not from the reporting year simply because they are good examples of the kind of work done by the HICAP.

- An older worker is a member of a Health Maintenance Organization (HMO). The HMO is the primary payer and should only bill Medicare as secondary payer. However, this HMO and its doctors billed Medicare as the first payer. Medicare paid the client who, in turn, paid his doctors and the HMO. When Medicare caught the errors, it requested a refund from the HMO. The HMO did not respond, so Medicare billed the client. The client explained the situation to Medicare, but Medicare insisted the client was liable for the overpayment which was in excess of $3,000. The client, out of desperation, contacted the HICAP when Medicare threatened to garnish his Social Security checks. The HICAP Counselor sent letters to the HMO which finally responded. The HMO had the doctors refund the $3,000 to Medicare. Medicare then dismissed the charges to the client.

- A distraught 72-year-old woman presented a letter to the local HICAP Counselor from a collection agency demanding payment of $1,947 for services received by her husband for his open heart surgery in 1986. The local HICAP project had been assisting the client and her husband with their medical billing and reimbursement off and on since 1985. The Counselor knew that the client did not have a bill for this amount and all other bills had been attended to and resolved for her husband's surgery. The letter contained no information to identify the provider of service (doctor), the date of service, nor the total of the bill. The client attempted to get this information from the collection agency and was confronted with a rude demand for payment. The local HICAP Counselor called the agency and spoke with an account representative who could not identify the provider and demanded an additional amount of money ($1,542), citing an error in the original letter which did not reflect the total amount due. Later on this "error" turned out to be an additional mistake by the collection agency because the charge had already been paid by Medicare and the client's supplemental insurance company.

  In a discussion with the account representative's supervisor, it was discovered that the HICAP client had been billed in error. The agency had not researched the client's account and did not know it had been an assigned claim for which no bill had ever been presented to the client for payment. The collection agency was provided sufficient information to correct the billing error which had occurred in 1986 when the client's doctor first billed Medicare. They agreed to cease all efforts to collect payment from the HICAP client and immediately sent a letter of apology to the client for any anxiety the firm had created. The local HICAP project saved the client $1,947 which would have been paid if HICAP had not intervened and an additional $1,542 which would have been paid if the second error had not been discovered.

- During March 1988, a lady with emphysema came into the HICAP project with a stack of Explanation of Medicare Benefits (EOMB) forms. On a few forms, Medicare had approved payment for oxygen and durable equipment; however, on others, both had been denied. The total amount denied was $1,177. The local HICAP Counselor assisted her with a request for reconsideration, which was denied. A request for a review was also denied. The HICAP participant was then assisted in the preparation and submission of a request for a Fair Hearing. The

Hearing Officer sent the participant a letter approving the entire amount. The letter was signed and returned to the Hearing Officer. Early in May 1988, the participant received $949.60 (80%) from Medicare, and the HICAP Counselor assisted the client with the submission of a supplemental insurance claim. By the end of May, the client had received $227.40 from her insurance company. She was reimbursed a total of $1,177.

- A HICAP client's husband had died of cancer. In addition to grieving her loss, the client had to contend with bills from 33 different providers. The local Counselor assisted the client by organizing and processing claims and payments during a period of several months. The Counselor also contacted the doctors to ask if they would accept assignment for their services. Many of the doctors agreed to accept assignment which saved the client between $4,000 and $5,000.
- A Spanish-speaking HICAP client visited the local HICAP project because he had numerous Medicare claims which were denied payment. Medicare had denied the claims because he had a group insurance policy. A HICAP Counselor determined that Medicare was wrong since the client had been retired for several years and his retirement plan did not include health insurance. The client had completed 2-3 questionnaires from Medicare stating that he was not employed, but the information was not entered correctly in Medicare's computer. By the time he visited the HICAP project, there was a considerable amount of money owed to the client. The HICAP Counselor called Medicare, the client's files were reexamined, and delayed payments were sent to the physicians. Medicare discovered an incorrect code was entered which indicated that another insurance claim was involved. Because of the language barrier, the Counselor wrote a letter for the client, which the client signed, outlining the problems. The letter also confirmed the previous telephone conversations and the proposed outcome by Medicare. Consequently, the client was extremely grateful that the Counselor had been able to accomplish in just two phone calls what he had been trying to achieve for many months.

E. CONCLUSION

The HICAP met its performance objectives for Fiscal Year 1988-89. The Program exceeded last year's overall performance. Reflecting the performance of all 24 projects, a comparison of the FY 1987-88 performance data with FY 1988-89 shows a 147 percent increase in the number of community education clients contacted, a 71 percent increase in the number of counseling client contacts, and a 34 percent increase in the number of legal client contacts.

The HICAP projects reported $4,689,231 in savings to 5,134 clients during FY 1988-89 for an average savings of $913.37 per person. This savings represents a 176 percent return in terms of cost savings compared to the expense of the Program. Within the total, $1,291,960 was reported saved for the State's Medi-Cal program. Although client savings were significant, the real benefits are derived from cost avoidance by preventing or postponing the need for people to rely on the State's Medi-Cal program.

The Health Insurance Counseling and Advocacy Program is a volunteer supported program that provides assistance with Medicare and health insurance. The HICAP is one among only a few programs in the nation committed solely to offering this unbiased assistance in Medicare and health insurance issues to the elderly population. The Program provides a needed service to California's older population, and the Department looks forward to continuing this progress in subsequent years.

Item 12

HUNTERDON COUNTY AREA AGENCY ON AGING
COMMUNITY SERVICES BUILDING
6 Gauntt Place
Flemington, N.J.08822

ROSEMARIE DOREMUS
Executive Director

Telephone:
201-788-1363
201-788-1362

DATE: February 16, 1990

TO: U. S. Senate Special Committee on Aging

FROM: Susan Chambers, Program Development Specialist
Hunterdon County Office on Aging, New Jersey

RE. Testimony - Victim of Unethical Marketing of Medigap Policy

In July 1986, Joyce C., a 67-year-old retired teacher living alone with her sister in their family home, stated to me that she felt afraid after having agreed by phone to have a man come to her house. She had been called on the telephone by a woman who asked if anyone over 65 resided there. The woman said that a representative of the "American (the teacher could remember no more) Company" would like to come to her home to explain the recent changes in Medicare. She was assured that "all seniors" in her area were being contacted.

Joyce C. and I made arrangements for me to go immediately to her home in order that I would be with her when the company representative arrived. Joyce C. introduced me to the representative as her friend, stating nothing about my position with the County Office on Aging.

Richard S., an Insurance Agent with the R.S. Hoffman Agency, 128 E. Broad Street, Bethlehem, PA 18018~~,~~ gave us his business card and spent half an hour describing Medicare and its shortcomings. He then gave us brochures on Policy A-MS-820 (NJ) offered by the American Progrssive Health and Life Insurance Company of New York. He asked and was told by Joyce C. that she had Blue Cross Blue Shield of New Jersey coverage through the New Jersey State Employees Health Benefits. He stated repeatedly that she need more....specifically the policy he was selling. He said that she needed double coverage, so the Blue Cross payments could go toward her hospital bills, and payments from his policy could be used to pay for home care during recovery after a hospital stay. Standing and waving and pointing directly at Joyce C., he stated, "I know many people who now have chronic illnesses, but who never thought it could happen to them." "What I am selling is peace of mind." "One thing you can count on as the months and years go by, there will be a much greater possibility, and probability, that you will need more insurance." He asked Joyce C. to sign a purchase agreement immediately, in order to get started right away into the 6 month pre-existing condition period. When Joyce C. stated her preference for reading the materials for a while and calling him if she were interested in buying, Richard S. became angry, quickly putting his papers back in his case, and silently hurrying to the door to leave.

I reported the above to the New Jersey Department of Insurance, in order that they could instruct his agency to use less forceful tactics in dealing with vulnerable senior citizens. Joyce C. did not choose to buy the policy sold by Richard S., but many less aware persons might have followed the firmly stated advice of the agent to protect themselves with double coverage.

This Agency does not discriminate on basis of handicap, race, sex, creed or national origin.